Supreme Court, U.S.
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In The

Supreme Court of the United States

CATHERINE ROBERSON,

Petitioner,

v.

ERIC K. SHINSEKI, Secretary of Veterans Affairs,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

In *Brown v. Gardner*, 513 U.S. 115, 115 S.Ct. 552, 130 L.Ed.2d 462 (1994), this Court held that former 38 U.S.C. §1151, Benefits for Persons Disabled by Treatment or Vocational Rehabilitation, does not contain a fault standard. The question presented is:

> Whether the decision of the United States Court of Appeals for the Federal Circuit is in conflict with *Brown v. Gardner* because it imposed a fault standard on §1151 claims which are based on agency acts of omission.

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PETITION FOR WRIT OF CERTIORARI

Petitioner Roberson respectfully petitions for a writ of certiorari to review the decision and judgment of the United States Court of Appeals for the Federal Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Federal Circuit (App. 1) is reported at 607 F.3d 809 (2010). The decision of the United States Court of Appeals for Veterans Claims (App. 21) is reported at 22 Vet. App. 358 (2009).

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Federal Circuit was entered on June 7, 2010. App. 20. This Court has jurisdiction under 28 U.S.C. §1254(1).

STATUTE INVOLVED

The statute involved, former 38 U.S.C. §1151, is reproduced in the appendix to this petition. App. 64.

STATEMENT OF THE CASE

Under 38 U.S.C. §1151, a United States military veteran may demonstrate entitlement to benefits for disabilities which result from Department of Veterans Affairs' (VA) hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation. *Brown v. Gardner*, 513 U.S. 115, 115 S. Ct. 552, 130 L.Ed.2d 462 (1994) addressed whether a VA regulation, which conditioned entitlement under former §1151 on a demonstration of VA fault or negligence, was consistent with the controlling statute. *Gardner* held that it was not.

> Without some mention of fault, it would be unreasonable to read the text of §1151 as imposing a burden of demonstrating it upon seeking compensation for further disability.

Gardner, *supra*, 115 S. Ct. at 556.

Thereafter, Congress amended former §1151 to insert a fault standard, effective October 1, 1997.[1] However, it is undisputed that Petitioner Roberson's claim was filed before the effective date of the amendment, so that she is entitled to have her claim adjudicated under the no-fault provisions of former §1151, as construed by *Gardner*.

---

[1] Pub. L. No. 104-204, Title IV, §442(a), 110 Stat. 2926 (September 26, 1996). It is undisputed that Petitioner Roberson's claim was pending before the effective date of the amendment, and that she is entitled to adjudication of her claim under the former §1151 no-fault standard.

At issue is whether the Federal Circuit's decision, which finds that there is a fault standard in some cases under the former §1151, is in conflict with the *Gardner* decision.

Petitioner Roberson's husband, Isaac Roberson, served in the United States Army from 1956 until 1959, when he was granted an honorable discharge. App. 2. For the last several years of his life, he regularly treated for a variety of ailments at VA medical facilities, including the Columbus, Ohio VA Outpatient Center, and VA Hospitals in Chillicothe, Ohio and Cincinnati, Ohio. CAVC decision, App. 22. Beginning in March 1993, he treated exclusively with VA medical providers over the next two years. App. 3.

In August 1995, Petitioner Roberson transported her husband to the Riverside Methodist Hospital, a private hospital, which admitted him through the emergency room. August 1995 ER report, App. 66. Testing revealed a small cell carcinoma with metastases to the brain, extensive involvement in the liver and subcutaneous masses, and possible metastases to the bones. App. 69. Mr. Roberson was found to have a persistent altered mental status. *Id.* He died on October 10, 1995, just two months after his cancer was diagnosed. The cause of death was cardiac arrhythmia due to pneumonia, which was due to metastatic cancer. Death Certificate, App. 73.

The medical evidence is in agreement that the onset of the veteran's cancer was within either four to eight months, or four to six months, prior to the

August 1995 initial diagnosis. Dr. Pritchard's report, App. 98; VA experts' report, App. 105. In other words, the onset of his small cell carcinoma was January 1995 at the earliest, and April 1995 at the latest.

The events which occurred in the eight months prior to diagnosis include the following:

1. The VA medical records showed a decline in the veteran's condition during his last year of life, in 1995. He was seen in January 1995 for modification of an orthotic and for stroke residuals, App. 78-79.

2. He was seen in February 1995 and noted to be scheduled for admission to the Chillicothe VA Medical Center for respite care, App. 79. He was subsequently discharged using a wheelchair, App. 80-83.

3. April 1995 VA Outpatient records report that the veteran now required assistive devices, that he had home health care three times per week, that he walked only with supervision, and that he was evaluated as only partially independent in activities of daily living. App. 84.

4. VA referred him to physical and occupational therapy, *id.*, but by May 3, 1995, VA treatment records reported decreased follow-through due to illness. App. 85.

5. He was seen by a VA physician a week later. The physician noted his symptoms but did not evaluate the cause except to generally attribute his

deterioration to his stroke history. App. 86. No clinical testing was ordered. Mr. Roberson was instructed to return in two months. *Id.*

6. In early June 1995, Petitioner Roberson took her husband to Riverside Methodist Hospital, a private hospital in Columbus, Ohio, because his speech was becoming increasingly slurred. App. 87. The tentative diagnosis was to rule out CVA/TIA [cerebrovascular accident and temporary ischemic attack]. However, objective testing of the brain via a CT scan was negative. App. 89. This is significant, because it supports that brain metastasis had yet occurred, even though all experts agree that his small cell carcinoma had its onset before this time. App. 98, 105.

7. Mr. Roberson continued to treat through the VA Outpatient Center. However, he made such poor progress with his VA-prescribed physical therapy that VA discontinued it. App. 91.

8. He had a follow up visit to the VA Outpatient Center on June 22, 1995. VA medical record, App. 92. The VA medical treatment provider found him to be agitated, anxious and frustrated because he was unable to do things or make himself understood. Without ordering clinical or other testing, the VA medical treatment provider diagnosed Mr. Roberson's deteriorating symptoms as "adjustment disorder." *Id.*

9. As discussed above, following a second Riverside Methodist Hospital visit, in August 1995, he was diagnosed with small cell carcinoma.

A fine needle biopsy was viewed as suggestive that the primary cancer was in the lung (App. 96). Dr. Pritchard stated that the veteran's small cell carcinoma was "advanced" at the time of diagnosis, with involvement in the brain, liver, lymph nodes, and lungs. App. 98. Dr. Pritchard was not asked, and did not provide, an opinion on whether VA medical care providers breached an applicable standard of care by not diagnosing his cancer at an earlier time.

VA's experts, physicians from the VA's Bronx Medical Center, stated that it was impossible to say if Mr. Roberson would have been cured if he had been diagnosed earlier; with brain involvement, they stated that with treatment, there is a median survival of 10 months. JA 128-129. (Mr. Roberson was treated, but did not meet the 10 month median survival time.) VA's experts disagreed that the lung was the primary site of the cancer, as they viewed other primary sites as possible.

VA requested that its experts offer their opinion on whether VA's failure to diagnose the veteran's cancer at an earlier time breached the standard of care. JA 124. The VA experts stated that VA medical providers did not breach the standard of care. They stated, "No." App. 106.

Petitioner Roberson filed a claim with the Department of Veterans Affairs (VA) Regional Office in Cleveland, Ohio, requesting that she be granted DIC

(dependents benefits) under former §1151, which provides that where a veteran suffered injury as the result of VA medical care, and that injury resulted in death, DIC compensation "shall be awarded in the same manner as if such . . . death were service-connected."

VA denied Mrs. Roberson's claim because it found that the evidence did not demonstrate that VA medical providers were negligent in failing to diagnose Mr. Roberson's cancer. The Veterans Court affirmed. It found persuasive the reasoning of the VA Office of General Counsel's Precedential Opinion, VAOPGCPREC 5-2001 (App. 42), which distinguished between former §1151 claims based on an act of "commission", and subject to *Gardner's* no-fault standards, vs. former §1151 claims based on an act of "omission", for which fault was "a necessary element of causation, rather than a separate and additional element." App. 33.

The Federal Circuit agreed, holding that, "A fault standard is needed in failure-to-diagnose claims under former §1151 because there would otherwise be no means for eliminating remote consequences or excluding coverage based on an injury's or a disease's natural progression." App. 14.

REASON FOR GRANTING THE WRIT

The Federal Circuit's decision is in conflict with *Brown v. Gardner*.[2]

Gardner addressed the question of whether former §1151 contains a fault standard. *Gardner* held clearly and unequivocally that it does not.

In *Gardner v. Derwinski*, 2 Vet. App. 178 (1992), the Veterans Court had invalidated an agency regulation, 38 C.F.R. §3.358(c)(3) (1990), which had inserted a fault standard into former §1151. As a result, the agency limited its §1151 liability to injuries which are the result of VA negligence. The Veterans Court held that §1151 neither imposed nor authorized a fault requirement.

In *Gardner v. Brown*, 5 Vet. App. 1456 (Fed. Cir. 1993), the Federal Circuit affirmed. It rejected the Secretary's argument that the §1151 "as the result of" language was ambiguous on the issue of whether §1151 contained a fault requirement.

The Secretary appealed. In *Brown v. Gardner, supra*, this Court stated that former §1151 contained not "so much as a word about fault on the part of VA." 115 S. Ct. at 554-555. *Gardner* goes on to hold, at page 556:

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[2] All references to "Gardner" are to the Supreme Court's decision, at 115 S.Ct. 552, unless stated otherwise.

> . . . Without some mention of the VA's fault, it would be unreasonable to read the text of §1151 as imposing a burden of demonstrating it upon [the claimant] seeking compensation for a further disability.
>
> In sum, the text [of former Section 1151] and reasonable inferences from it give a clear answer against the government, and that, as we have said, is "'the end of the matter.'" *Good Samaritan Hosp. v. Shalala*, 508 U.S. ___, ___, 113 S. Ct. 2151, 2157, 124 L.Ed.2d 368 (1993) (quoting *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S. Ct. 2778, 2781, 81 L.Ed.2d 694 (1984). Thus this clear textually grounded conclusion in Gardner's favor is fatal to the remaining principal arguments advanced against it.

The clear language of the *Gardner* decision bars the reinsertion of fault language in a case brought under former §1151. This is the point at which the Federal Circuit impermissibly departed from *Gardner*, in the instant case. Section 1151 does not contain any fault language, it would be unreasonable to read fault language into the statute, and that is the end of the matter.

The Federal Circuit's reasons for inserting a negligence standard into former Section 1151 do not support its decision.

First, the Federal Circuit's analysis turns on the creation of two subcategories, acts of commission and

acts of omission. The court indicates that a failure to diagnose is an act of omission. App. 15. However, former §1151 refers to "an injury, or an aggravation of an injury, as the result of hospitalization, medical or surgical treatment, or the pursuit of vocational rehabilitation" which "results in additional disability to or the death of such veteran." There is no language in former §1151 which even suggests that Congress intended to create two subcategories of §1151 claims, and then assign disparate standards – a fault standard in one, a no-fault standard in the other.

The VA General Counsel's opinion, VAOPGCPREC 5-2001, which both the Veterans Court and the Federal Circuit relied upon, concedes this point:

> The language of section 1151 does not suggest any intent to draw a distinction between acts of commission and acts of omission.

App. 45.

Significantly, the Federal Circuit did not interpret former §1151 as excluding acts of omission from the injuries which §1151 is intended to compensate. That §1151 contemplates both acts of commission and acts of omission also is consistent with VAOPGCPREC 5-2001. It states:

> . . . because nothing in section 1151 suggests a need to distinguish between acts of commission and acts of omission, we need not address whether it is possible to state an intelligible distinction between the two. Based on the plain language of the statute,

> we conclude that 38 USC §1151 authorizes compensation without regard to whether the circumstances causing or aggravating the injury in question may be characterized as omissions or acts of commission.

App. 47-48.

Second, the Federal Circuit rejected Petitioner Roberson's position – that a claimant can demonstrate causation without including a fault standard or proving a breach of duty – on the stated ground that her position overlooks the proximate cause requirement. App. 14. However, *Gardner* expressly rejected the notion that former §1151 implicated a fault standard as part of the proximate cause requirement. At 115 S. Ct. At 555-556, *Gardner* states:

> In a second attempt to impose a VA-fault requirement, the Government suggests that the "as a result of" language of §1151 signifies a proximate cause requirement that incorporates a fault test. Once again, we find the suggestion implausible. This language is naturally read simply to impose the requirement of a causal connection between the "injury" or "aggravation of an injury" and "hospitalization, medical or surgical treatment, or the pursuit of a course of vocational treatment."

Third, the Federal Circuit concluded that Petitioner Roberson's position "fails to provide a sufficiently discernable standard for distinguishing "failure to diagnose" claims that are compensable

from those that are not. App. 14. "Without a showing that the VA should have diagnosed a condition, the VA would be subject to insuring for every possible condition that a veteran has, even if unrelated to service or VA treatment. Similarly, without a showing that the VA should have diagnosed the condition, the VA would be subject to insuring for an injury's natural progression." App. 15.

However, *Gardner* discussed and rejected the government's argument that VA could narrow the class of compensable cases by inserting a fault standard. *Gardner* held, at 115 S. Ct. at 556:

> Assuming that the connection is limited to proximate causation so as to narrow the class of compensable cases, that narrowing occurs by eliminating remote consequences, not by requiring a demonstration of fault.

Thus, consistent with *Gardner*, a fault standard cannot be read into former §1151, and the concerns expressed by the court below can be met through other methods. These other methods include not only *Gardner's* remote consequences analysis, but also regulatory provisions that were in place even before the *Gardner* decision, and which effectively apply a remote consequences test. Those provisions, which were not at issue in *Gardner* and thus not invalidated thereby, address the same concerns which the Federal Circuit raised below, in Petitioner Roberson's decision, but they do so in a way that does not require reinsertion of a fault standard into former §1151 – a

solution which is not available to the government under *Gardner*.

Former 38 C.F.R. §3.357(c) (1990) states that in determining causation:

> (1) It will be necessary to show that the additional disability is actually the result of such disease or injury or an aggravation of an existing disease or injury and not merely coincidental therewith.
>
> (2) The mere fact that aggravation occurred will not suffice to make the additional disability compensable in the absence of proof that it resulted from disease or injury or an aggravation of an existing disease or injury suffered as the result of training, hospitalization, medical or surgical treatment, or examination.

Read together, §3.358(c)(1) and (2) avoid the dire results that the Federal Circuit contemplated in the decision below. In the case of a failure to diagnose, the regulations eliminate remote consequences as well as "natural progression" because remote consequences and natural progression of a disability are not "actually the result" of the mis-diagnosis or non-diagnosis of a disease or injury within the meaning of the regulations.

In Petitioner Roberson's case, the veteran's additional disability which resulted from the delay in diagnosis and treatment was the metastasis of his cancer from its primary site (whether the lung, as

Dr. Pritchard opined, or some other unidentified site, as VA's experts opined) to his brain and other parts of his body; and progression of his cancer 1) beyond the point that his small cell carcinoma was sensitive to treatment, and 2) such that Mr. Roberson was unable to survive even the median time for brain cancer patients who are treated. The delay in diagnosis and treatment hastened his death.

The decision below, that former §1151 includes a fault standard in cases which are based on VA acts of omission, was prejudicial to Petitioner Roberson. The Board of Veterans' Appeals developed her case as a medical negligence case, including obtaining a medical opinion in light of negligence standards. See, BVA letter to its experts, App. 111. Petitioner Roberson agrees that she did not submit expert medical evidence to rebut VA's experts' opinion on breach of a standard of care. However, under a correct reading of former §1151, evidence of breach of the standard of care is irrelevant to the merits of her claim. The denial of her claim on the ground that failure to diagnose claims require evidence of medical negligence cannot be reconciled with *Gardner's* decision that a fault element cannot be read into former §1151.

CONCLUSION

The petition for a writ of certiorari should be granted to address the conflict between *Gardner* and

the Federal Circuit's decision in Petitioner Roberson's case.

Respectfully submitted,

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United States Court of Appeals
Federal Circuit

CATHERINE ROBERSON,
Claimant-Appellant,

v.

ERIC K. SHINSEKI, Secretary of Veterans Affairs,
Respondent-Appellee.

2009-7093

Appeal from the United States Court of Appeals for Veterans Claims in 05-3243, Judge Alan G. Lance, Sr.

Decided: June 7, 2010

SANDRA E. BOOTH, Sandra E. Booth Attorney at Law, of Columbus, Ohio, argued for claimant-appellant.

ALLISON KIDD-MILLER, Trial Attorney, Commercial Litigation Branch, Civil Division, United States Department of Justice, of Washington, DC, argued for respondent-appellee. With her on the brief were TONY WEST, Assistant Attorney General, JEANNE E. DAVIDSON, Director, and MARTIN F. HOCKEY, Jr., Assistant Director. Of counsel on the brief were MICHAEL J.

TIMINSKI, Deputy Assistant General Counsel, and AMANDA R. BLACKMON, Attorney, Office of the General Counsel, United States Department of Veterans Affairs, of Washington, DC.

Before BRYSON and MOORE, *Circuit Judges*, and FOLSOM, *Chief District Judge*.[1]

FOLSOM, *Chief District Judge*.

Appellant Catherine Roberson appeals the decision of the Court of Appeals for Veterans Claims (Veterans Court) affirming the Board of Veterans' Appeals (Board) decision denying Mrs. Roberson's claim for death and indemnity compensation (DIC) pursuant to former 38 U.S.C. § 1151 for her husband's death from non-service-connected cancer. Because the Veterans Court properly interpreted former 38 U.S.C. § 1151, we affirm.

BACKGROUND

Mrs. Roberson's late husband, Isaac Roberson, served in the United States Army from 1956 until he was granted an honorable discharge in 1959. His medical history includes a heart attack in 1974 and a nondisabling cerebrovascular accident (CVA) or stroke in 1974 with a second CVA in 1990, which left

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[1] The Honorable David Folsom, United States District Court for the Eastern District of Texas, sitting by designation.

the veteran with some paralysis on his left side. There is no claim that the heart attack or CVAs are service-connected.

Mr. Roberson regularly received treatment at VA medical facilities, including the Columbus, Ohio VA Outpatient Center and VA hospitals in Chillicothe and Cincinnati, Ohio. He also occasionally was treated by emergency room personnel at Riverside Methodist Hospital (Riverside), a private facility in Columbus, Ohio. Beginning in March 1993, Mr. Roberson was treated exclusively by VA providers over the next two years. In January 1995, he visited the Columbus, Ohio VA Outpatient Center for modification of an orthotic and for stroke follow-ups. His last VA hospital admission prior to his death was in March 1995, when he was seen for a period of respite care. At that time, Mr. Roberson had no specific complaints other than a "head cold," and he was treated for mild pharyngitis. In May 1995, Mr. Roberson was seen by a VA physician who noted his increasing symptoms (greater use of assistive devices, cane, grab bars, lift chair), but attributed those symptoms to his history of strokes.

In June 1995 Mrs. Roberson took her husband to Riverside after he began experiencing slurred speech and intermittent vision impairment. The computed tomography (CT) scan performed at Riverside yielded negative results. Later that month, Mr. Roberson visited Riverside for a follow-up examination at which time the treatment provider found him to be agitated, anxious, and frustrated because he was unable to do

things or make himself understood. The treatment provider diagnosed Mr. Roberson with "adjustment disorder."

Mr. Roberson was again admitted to Riverside through its emergency room in August 1995. During this visit, however, a CT scan showed a significant obstructed hydrocephalus – a condition characterized by abnormal accumulation of fluid in the cranial vault – with a mass in the right cerebellum. The subsequent magnetic resonance imaging (MRI) showed a five centimeter mass and metastasis in the right cerebellum. Mr. Roberson also had extensive involvement in the liver and subcutaneous masses with possible metastasis to bone. The physician's clinical impression was to "rule out prostatic carcinoma with cerebral metastasis." A consultation report prepared at the time by Riverside physician Dr. James D. Pritchard indicated that the origin of Mr. Roberson's cancer was "most likely" in the lung although other sources could not be ruled out. Mr. Roberson died two months later in October 1995 from cardiac arrhythmia caused by pneumonia brought on by the metastatic cancer.

At the time of his death, Mr. Roberson had an appeal pending for compensable ratings for arthritis of his left foot and right great toe. In February 1996, appellant Mrs. Roberson filed a claim for accrued benefits based on her husband's increased ratings that were pending. Three months later, she filed a claim for DIC benefits based on the contention that her husband's death resulted from his treatment at

the VA medical facility. Specifically, Mrs. Roberson claimed that the VA physicians failed to diagnose her late husband's cancer and that this failure hastened his death. In June 1996, the VA Regional Office denied Mrs. Roberson's DIC claim because the evidence failed to show that the cause of Mr. Roberson's death was related to his military service or to a service-connected condition. Mrs. Roberson persisted, but in September 1996 the Regional Office denied her claim based on former 38 U.S.C. § 1151.

In November 1998, the Board similarly denied DIC benefits based on a lack of service connection for the cause of Mr. Roberson's death and under former § 1151. The Board, however, granted entitlement to accrued benefits and assigned 10% disability ratings for Mr. Roberson's left foot and right toe disabilities. The Veterans Court nevertheless vacated the Board's November 1998 decision and remanded the matter for further development, including compliance with the Veterans Claims Assistance Act of 2000, Pub. L. No. 106-475, 114 Stat. 2096. *See Roberson v. Principi*, No. 99-352, 2001 WL 290189, at *3 (Vet. App. Mar. 22, 2001).

Upon the Board's request for additional development, two VA physicians from the Bronx, New York VA medical center provided an opinion in July 2003 regarding Mr. Roberson's cancer and death. In that opinion, the physicians stated that although the primary site of the cancer was undetermined, the "possible primary sites for this cancer include head and neck tumors, prostate, and bowel." Onset of the

cancer occurred four to six months before the August 1995 diagnosis, concluded the VA physicians. The VA physicians also noted that "neither of the brain metastases was detectable on [a] CT scan of the head in June, 1995" and that "the second of the two brain metastases was undetectable on CT scan of the head on 8/14/95, two days before it was discovered on 8/16/95." According to the VA physicians, "the multiple scans and x-rays that were performed in 1995 prove that the disorder was first manifested in August, 1995" and "was not present on testing prior to July, 1995."

The Board also asked the VA physicians to answer specific questions, including:

> Did VA fail, during a period of VA treatment, to diagnose the disorder which caused the veteran's death, when a physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment?

The VA physicians were additionally asked to determine whether the veteran suffered any additional disability or death as a result of the VA's failure to diagnose the veteran's cancer. In response, the VA physicians stated:

> There are no symptoms recorded during the episodes of VA treatment suggestive of a medical condition that warranted further investigation. In the absence of a history to suggest a disorder other than the multiple

> strokes, and in the absence of a change in physical findings to suggest a new or worsening process, further investigative studies were not clinically indicated.
>
> The VA physicians added:
>
> It is impossible to say if [the veteran] could have been cured if the disease had been detected earlier. Death from extensive small cell carcinoma with brain involvement usually, but not always, results in death within 10 months. Any individual patient, however, may not follow this statistic. Small cell carcinomas have a median survival with treatment of 10 months.

The Board on remand also considered a January 1998 letter Dr. Pritchard wrote on behalf of Mrs. Roberson in which he opined that as of August 1995, Mr. Roberson "already had brain involvement from his tumor, and in addition, the C[ ]T scan showed extensive involvement in the liver, lymph nodes, and lung. Therefore his disease was advanced at the time of diagnosis." Dr. Pritchard's letter also stated that the small cell carcinoma had "advanced very quickly and had not been present for a long period of time" with an estimated "onset of perhaps four to eight months prior to the diagnosis."

After reviewing the opinions of the VA physicians, Dr. Pritchard's letter, Mrs. Roberson's lay opinions, and the rest of the evidentiary record, the Board found "no evidence of record suggesting that VA treatment, specifically the lack of a diagnosis of

[Mr. Roberson's] small cell carcinoma, had the effect of hastening [Mr. Roberson's] death." *See Bd. Vet. App. 0525865,* 2005 WL 3916807 (2005).

Mrs. Roberson appealed the Board's decision to the Veterans Court asserting that VA treatment, that is, the failure to diagnose her husband's cancer, had the effect of hastening his death. The Veterans Court affirmed and held that the Board's decision that Mrs. Roberson had not proven her claim to entitlement to DIC benefits under former 38 U.S.C. § 1151 by a preponderance of the evidence was not clearly erroneous. *Roberson v. Shinseki,* 22 Vet. App. 358, 366 (2009). In so finding, the Veterans Court concluded that Mrs. Roberson "has not shown that VA should have diagnosed the veteran's cancer prior to his actual diagnosis." *Id.*

DISCUSSION

This Court has jurisdiction pursuant to 38 U.S.C. § 7292(c). We review statutory interpretation by the Veterans Court *de novo. Glover v. West,* 185 F.3d 1328, 1331 (Fed. Cir. 1999). Absent a constitutional issue, we may not review challenges to factual determinations or challenges to the application of a law or regulation to facts. 38 U.S.C. § 7292(d)(2) (2006).

The main issue is whether the Veterans Court correctly interpreted the previous version of 38 U.S.C. § 1151 by finding that a claim based on an alleged failure to diagnose requires the claimant to show that VA should have diagnosed the condition in question.

The current version of 38 U.S.C. § 1151 provides benefits for a death or disability resulting from VA medical treatment in the same manner as for a service-connected death or disability. This current version of the statute requires the putative claimant to demonstrate "carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on the part of the Department in furnishing the hospital care, medical or surgical treatment, or examination." *See* 38 U.S.C. § 1151(a)(1)(A).[2] This current version originated as a response to the United States Supreme Court's decision in *Brown v. Gardner,* 513 U.S. 115 (1994). In *Gardner,* the claimant, Mr. Gardner, received surgical treatment at a VA medical center for a herniated disc unrelated to his prior military service. He then experienced pain and weakness in his left calf, ankle, and foot, which he alleged was the result of the surgery and claimed disability benefits under the previous version of § 1151. The previous version of 38 U.S.C. § 1151 provided:

> Where any veteran shall have suffered an injury, or an aggravation of an injury, as the result of hospitalization, medical or surgical treatment . . . or as a result of having

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[2] Congress amended 38 U.S.C. § 1151 in 1996. *See* Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, Pub. L. No. 104-204, 110 Stat. 2874, 2927 (1996). When this opinion refers to "former § 1151" or the "previous version of 38 U.S.C. § 1151," it refers to the statute prior to its amendment in 1996.

> submitted to an examination . . . , and not the result of such veteran's own willful misconduct, and such injury or aggravation results in additional disability to or the death of such veteran, disability or death compensation . . . shall be awarded in the same manner as if such disability, aggravation, or death were service-connected.

Pub. L. No. 85-857, 72 Stat. 1105, 1121 (1958) (renumbered § 1151 at Pub. L. No. 102-83, 105 Stat. 378,406 (1991)).

The VA and the Board denied Mr. Gardner's claim. Both the VA and the Board relied on 38 C.F.R. § 3.358(c)(3) (1993), which permitted recovery under former § 1151 only if the injury "proximately resulted [from] carelessness, negligence, lack of proper skill, error in judgment, or similar instances of indicated fault" on the part of the VA, or from the occurrence during treatment or rehabilitation of an "accident," defined as an "unforeseen, untoward" event. *Gardner,* 513 U.S. at 117. The Veterans Court reversed the Board's decision and the Federal Circuit affirmed the Veterans Court's judgment. *Gardner v. Derwinski,* 1 Vet. App. 584 (1991), *aff'd sub nom. Gardner v. Brown,* 5 F.3d 1456 (Fed. Cir. 1993). In affirming, the Supreme Court stated:

> This language [of former § 1151] is naturally read simply to impose the requirement of a causal connection between the "injury" or "aggravation of an injury" and "hospitalization, medical or surgical treatment, or the

> pursuit of a course of vocational rehabilitation." Assuming that the connection is limited to proximate causation so as to narrow the class of compensable cases, that narrowing occurs by eliminating remote consequences, not by requiring a demonstration of fault.

Gardner, 513 U.S. at 119. Thus, according to the *Gardner* Court, "the text and reasonable inferences from it give a clear answer" that a claimant need not prove fault in order to recover under former § 1151. *Id.* at 120.

The claimant in *Gardner* sought relief for aggravation connected to VA treatment. In subsequent cases, however, the VA and the Board repeatedly faced the situation of § 1151 claims for a VA failure to treat or diagnose. As a result, the Board requested a legal opinion from the VA General Counsel about whether former § 1151 authorizes compensation for claims based on a VA omission or failure to diagnose, and if so, what essential elements of such a claim must be established in order for a claimant to prevail on such a claim. In February 2001, the VA General Counsel issued its opinion (GC Opinion). According to the GC Opinion, neither the language of former § 1151 nor its legislative history suggests an intent to distinguish between acts of commission, i.e. treatment or surgery, and acts of omission such as a failure to diagnose. With respect to the elements of a claim based on a failure to diagnose or treat, the GC Opinion stated that the entitlement to benefits based

on such a claim would ordinarily require a determination that: (1) the VA failed to diagnose and/or treat a preexisting disease or injury; (2) a physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment; and (3) the veteran suffered disability or death which probably would have been avoided if proper diagnosis and treatment had been rendered.

The GC Opinion recognized that the second element ostensibly conflicts with the *Gardner* decision; however, the GC Opinion also recognized that the *Gardner* decision plainly required a showing of a causal connection between an injury or aggravation of an injury and VA hospitalization or treatment. Under the common law pertaining to claims based on a failure to diagnose, the GC Opinion reasoned, a showing that the failure was due to the lack of ordinary care or skill is a necessary element of establishing the causal relationship between treatment and injury. The VA General Counsel added that the *Gardner* Court removed the necessity of showing fault in addition to showing causation but did not address whether showing a failure to exercise ordinary care constituted an element of entitlement.

Mrs. Roberson primarily argues that the Veterans Court and the VA General Counsel erroneously reinterpreted the *Gardner* ruling and reinserted a negligence or fault standard into 38 U.S.C § 1151 (1996) for one class of cases: acts of omission. According to Mrs. Roberson, *Gardner* is binding judicial

precedent and the Veterans Court cannot revisit the previous version of 38 U.S.C. § 1151 and reinsert a fault standard into a statute, the language of which the Supreme Court found to be clear. With respect to the GC Opinion, Mrs. Roberson contends that it confuses the element of causation with the principle of liability thus rendering it legally incorrect. Mrs. Roberson adds that whether an injury was the result of VA medical care is a wholly separate inquiry from whether the VA providers were negligent for former § 1151 purposes.

In response, the government argues that the Veterans Court permissibly interpreted the previous version of 38 U.S.C. § 1151 as applied to claims that the VA failed to diagnose a disease or condition. The government submits that the *Gardner* decision did not address the question presented in this case, to wit, what former § 1151 requires a claimant to demonstrate when he or she alleges that VA's failure to diagnose a disease caused an additional disability or death. Since the *Gardner* Court left open the question of whether or how an omission, such as a failure to diagnose, causes a particular claimant additional disability, the Veterans Court's interpretation rests upon a permissible construction of the statute, the government adds. In the alternative, the government argues that the Board's factual finding that no evidence of record suggested that the VA's lack of diagnosis had the effect of hastening Mr. Roberson's death supports the denial of Mrs.

Roberson's claim and that this Court does not have the jurisdiction to review such a finding.

Mrs. Roberson claims that VA's failure to diagnose and treat her husband's cancer resulted in additional disability and hastened his death. As the *Gardner* Court stated, however, demonstrating a "causal connection between the 'injury' or 'aggravation of an injury' and 'hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation'" is a fundamental prerequisite to recovery under the previous version of 38 U.S.C. § 1151. *Gardner*, 513 U.S. at 119. Establishing this causal connection, also called "proximate causation" by the Court, separates the compensable claims from the non-compensable claims. *Id.* Neither party disputes this proximate causation requirement; however, Mrs. Roberson's position – that a claimant can demonstrate causation without including a fault standard or proving a breach of duty – overlooks this proximate cause requirement. Put another way, Mrs. Roberson's position fails to provide a sufficiently discernable standard for distinguishing the "failure to diagnose" claims that are compensable from those that are not. A fault standard is needed in failure-to-diagnose claims under former § 1151 because there would otherwise be no means for eliminating remote consequences or excluding coverage based on an injury's or a disease's natural progression. *Id.*; *see also id.* at n.3.

As the GC Opinion recognized, a fault requirement appears at first blush to be inconsistent with

Gardner. However, Mr. Gardner sought recovery for aggravation of injury resulting from the VA's surgical treatment – an act of commission – while Mrs. Roberson seeks to recover for VA's failure to diagnose – an act of omission. Contrary to Mrs. Roberson's argument, this distinction is neither insignificant nor illusory. In a commission case, a claimant may meet his or her burden as to causation but not as to negligence. For example, Mr. Gardner may be able to establish that VA surgical treatment caused the weakness in his left leg, ankle, and foot but not be able to establish that the VA negligently performed the surgery. The *Gardner* Court held that such circumstances did not preclude recovery under former § 1151. In an omission case, by contrast, the only way to show causation is to demonstrate that the VA failed to diagnose when it should have. Without a showing that the VA should have diagnosed a condition, the VA would be subject to insuring for every possible condition that a veteran has, even if unrelated to service or VA treatment. Similarly, without a showing that the VA should have diagnosed the condition, the VA would be subject to insuring for an injury's natural progression.

Mrs. Roberson would have the test focus on determining whether an "injury" or "aggravation of an injury" is a "remote consequence" under *Gardner* based on the scope of the VA's medical undertaking. For example, if a veteran has a tooth filled, the VA's failure to diagnose cancer of the foot would be unrecoverable under former § 1151 as a "remote

consequence" of the dental treatment. But the VA's failure to diagnose cancer of the throat would be a "closer call" under Mrs. Roberson's test. In this case, Mrs. Roberson contends that VA's evaluation of her husband's deteriorating condition and subsequent diagnosis as "adjustment disorder" removes his injury or aggravation from the category of remote consequences. This amorphous "scope" or "purpose" of the VA's medical undertaking standard provides little guidance and would be unworkable. VA's treating of Mr. Roberson for stroke-related symptoms does not establish *ipso facto* that it should have diagnosed his brain metastasis. Further, any kind of mere temporal or physiological relation alone does not suffice. Such a claim cannot be recoverable under former § 1151 unless a claimant proves that VA should have diagnosed the condition. Indeed, Mrs. Roberson's "scope of undertaking" rule implicates a fault standard or breach of duty by basing a claimant's recovery on what the VA should have done during examination, diagnosis, and treatment. It cannot be the rule that because the VA was Mr. Roberson's primary caregiver, any omissions should be charged against it just as any commissions might be. Such a rule would wholly ignore the element of causation. The mere fact that VA provided care, even exclusively, cannot by itself mean that VA's failure to diagnose caused aggravation of injury or hastened the veteran's death. At most, exclusive care by the VA may be a factor in determining whether it breached any duty to a veteran by failing to diagnose a disease.

Contrary to Mrs. Roberson's argument, the Board did not err as a matter of law by requiring her to prove that the VA should have diagnosed her late husband's cancer. Where a claimant seeks to recover under the previous version of 38 U.S.C § 1151 for VA's failure to diagnose, it is impossible to delineate proximate cause without speaking in terms of duty. The Board applied the proper legal standard and determined that no evidence of record suggested that VA treatment had the effect of hastening Mr. Roberson's death. Specifically, the Board found that "[n]one of the disorders leading to death were hastened on account of any incident of VA treatment." The Board concluded that the preponderance of the evidence was against Mrs. Roberson's claim for DIC benefits under former § 1151.

Also, Mrs. Roberson does not contend that the Board erred by discounting her lay opinion as the only direct evidence supporting her claim. This Court lacks jurisdiction to review the Board's factual finding that Mrs. Roberson failed to meet her burden as to causation. *See* 38 U.S.C. § 7292 (absent a constitutional issue, this court "may not review (A) a challenge to a factual determination, or (B) a challenge to a law or regulation as applied to the facts of a particular case"). Mrs. Roberson concedes that unless the Board applied an incorrect standard, its factual determination is beyond our review.

The Veterans Court applied the law to the facts of Mrs. Roberson's case and affirmed, stating that "the appellant has not shown that VA should have

diagnosed the veteran's cancer prior to his actual diagnosis." The Veterans Court reviewed the Board's determination that the preponderance of the evidence was against her claim of entitlement under the correct legal standard by requiring Mrs. Roberson to prove that the VA should have diagnosed Mr. Roberson's cancer. Therefore, the Veterans Court did not misinterpret the previous version of 38 U.S.C. § 1151 in affirming the Board's decision.[3]

In sum, to recover under the previous version of 38 U.S.C. § 1151 for an alleged failure to diagnose or similar act of omission, a claimant must establish that the VA should have diagnosed or acted but failed to do so. This is not an element in addition to causation. Instead, it serves as the means of establishing the causal connection, or proximate cause, between the injury or the aggravation of the injury and the VA treatment.

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[3] In its opinion, the Veterans Court defined "injury" or "aggravation of an injury" to be the "failure to diagnose the condition." Under *Gardner*, however, the "injury" for purposes of 38 U.S.C. § 1151 (1996) is the undiagnosed or untreated condition. *Gardner*, 513 U.S. at 118-119. Nevertheless, the Veterans Court's reasoning – that a claimant cannot demonstrate an injury unless it is shown that VA should have diagnosed the condition – accords with the proper legal standard and the requirement of showing causation in claims under former § 1151. Therefore, the Veterans Court's definitions of "injury" or "aggravation of an injury" does not affect our present conclusion.

CONCLUSION

Because the Veterans Court correctly interpreted the elements required for a claimant's recovery under the previous version of 38 U.S.C. § 1151, the decision of the Veterans Court is

AFFIRMED.

COSTS

No Costs.

United States Court of Appeals
for the Federal Circuit

2009-7093

CATHERINE ROBERSON,

Claimant-Appellant,

v.

ERIC K. SHINSEKI, Secretary of Veterans Affairs,

Respondent-Appellee.

Judgment

ON APPEAL from the United States Court of Appeals for Veterans Claims in CASE NO. 05-3243.

This CAUSE having been heard and considered, it is

ORDERED and ADJUDGED:

AFFIRMED

ENTERED BY ORDER
OF THE COURT

DATED JUN - 7 2010 /s/ Jan Horbaly/ [CMC]
Jan Horbaly, Clerk

ISSUED AS A MANDATE: AUG – 6 2010

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 05-3243

CATHERINE ROBERSON, APPELLANT,

v.

ERIC K. SHINSEKI,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

On Appeal from the Board of Veterans' Appeals

(Argued October 7, 2008 Decided February 4, 2009)

Sandra E. Booth, of Columbus, Ohio, for the appellant.

Thomas E. Sullivan, with whom *Paul J. Hutter*, General Counsel, *R. Randall Campbell*, Assistant General Counsel, and *Gayle E. Strommen*, Deputy Assistant General Counsel, were on the brief, all of Washington, D.C., for the appellee.

Before GREENE, *Chief Judge*, and LANCE and SCHOELEN, *Judges*.

LANCE, *Judge*: The appellant, Catherine Roberson, appeals through counsel a September 21, 2005, decision of the Board of Veterans' Appeals (Board) denying entitlement to dependency and indemnity compensation (DIC) benefits under 38 U.S.C. § 1151 for the cause of death of the veteran, the appellant's late husband Isaac Roberson, Jr. The Board also denied entitlement to accrued benefits based on disability ratings in excess of 10% for the veteran's foot-related disabilities. The parties each filed briefs,

the appellant filed a reply brief, and, pursuant to an order by the Court, the parties filed supplemental briefs. The Court heard oral argument in the case. For the reasons that follow, we will affirm the Board decision.

I. BACKGROUND

The veteran served on active duty from February 1956 to February 1959. Record (R.) at 19. He had a heart attack in 1974 and cerebrovascular accidents (CVAs) in 1978 and 1990. After 1990, the veteran regularly received treatment at VA medical facilities, including the Columbus, Ohio, outpatient center and VA hospitals in Chillicothe and Cincinnati, Ohio. The veteran also occasionally visited the emergency room at Riverside Methodist Hospital (Riverside), a private facility in Columbus, Ohio.

The veteran was treated at the outpatient center throughout 1994 and received rehabilitative services in 1994 and 1995. R. at 822-24, 826-92. In March 1995, he was admitted to the Chillicothe VA hospital for respite care. R. at 687. In June 1995, the veteran was seen at Riverside for a possible stroke. A computed tomography (CT) scan performed at that time was negative. R. at 775. Also in June 1995, the veteran visited a VA facility and was given a tentative diagnosis of having an adjustment disorder. R. at 815-16.

Two months later, in August 1995, the veteran was again seen at the Riverside emergency room. R. at 1018. The emergency room physician's note

indicates that the veteran's medical history included multiple strokes and a carcinoma of the prostate. R. at 1018. A CT scan showed a possible metastatic area in the posterior fossa. The physician's clinical impression was "rule out prostatic carcinoma with cerebral metastasis." R. at 1019. The discharge summary notes that the CT scan indicated a 5 cm mass in the right cerebellum. R. at 1014. The summary also notes that the veteran had involvement in the liver and had multiple subcutaneous masses. R. at 1014. A CT scan of the chest did not show that the veteran's lung was the primary source of the cancer. R. at 1014. An August 1995 consultation report prepared by Dr. James D. Pritchard indicates that the origin of the veteran's cancer was "most likely" in the lung although other sources could not be ruled out. R. at 1048.

The veteran died in October 1995. R. at 780. The cause of death was reported to be cardiac arrhythmia due to pneumonia caused by metastatic cancer and status post CVA. R. at 780, 786. At the time of his death, the veteran had an appeal pending for compensable ratings for arthritis of his right great toe and left foot. R. at 669-71, 792-94.

In February 1996, the appellant, the veteran's widow, filed a claim for accrued benefits based on her husband's increased-ratings claims that were pending at the time of his death. R. at 796-97. In May 1996, the appellant filed a claim for DIC benefits, asserting that the veteran's death was due to his treatment at the VA medical center. R. at 799-802. Specifically, the

appellant contends that VA physicians failed to diagnose the veteran's cancer and that this failure hastened his death. Appellant's Brief (Br.) at 14.

In June 1996, a VA regional office (RO) denied the appellant's DIC claim because the evidence failed to show that the cause of the veteran's death was related to his military service or to a service-connected condition. R. at 804-05. The RO also denied entitlement to accrued benefits based on the veteran's foot disabilities. R. at 804. The appellant disagreed, reiterating her belief that VA failed to diagnose the veteran's cancer in a timely manner. R. at 811. In September 1996, the RO denied the appellant's claim for DIC based on the cause of the veteran's death under section 1151. R. at 913-15. A contemporaneous Statement of the Case (SOC) confirmed the denial of accrued benefits. R. at 919-28. The appellant perfected her appeal to the Board in October 1996. R. at 987-88.

In January 1998, Dr. Pritchard wrote a letter in support of the appellant's claim and attached a copy of his August 1995 consultation report. R. at 1054. Dr. Pritchard opined that, in August 1995, the veteran "already had brain involvement from his tumor, and in addition, the C[ ]T scan showed extensive involvement in the liver, lymph nodes, and lung. Therefore his disease was advanced at the time of diagnosis." R. at 1054. Dr. Pritchard further stated that the veteran's small-cell carcinoma had likely "advanced very quickly and had not been present for a long period of

time," and estimated an "onset of perhaps four to eight months prior to the diagnosis." R. at 1054.

In November 1998, the Board denied DIC benefits based on service connection for the cause of the veteran's death, as well as under section 1151. R. at 1100. The Board also granted entitlement to accrued benefits and assigned 10% disability ratings for the veteran's service-connected right-toe and left-foot disabilities. *Id.* On appeal to the Court, the Board's November 1998 decision was vacated and the matters were remanded for further development, including compliance with the Veterans Claims Assistance Act of 2000 (VCAA), Pub. L. No. 106-475, 114 Stat. 2096. R. at 1139-42.

In March 2002, the Board requested additional development, including review of the evidence by a VA oncologist. R. at 1204. Two VA physicians, from the Bronx, New York, VA medical center, provided an opinion in July 2003. R. at 1218-21. The physicians stated that the primary site of the veteran's cancer was undetermined and that "possible primary sites for this cancer include head and neck tumors, prostate and bowel." R. at 1220. They placed the onset of the veteran's cancer at four to six months before the August 1995 diagnosis, and noted that "[n]either of the brain metastases was detectable on [a] CT scan of the head [in] June, 1995." *Id.* The physicians also noted that "[t]he second of the two brain metastases was undetectable on CT scan of the head on 8/14/95, two days before it was discovered on 8/16/95." *Id.* According to the physicians, "the multiple scans and

x-rays that were performed in 1995 prove that the disorder was first manifested in August, 1995," and "was not present on testing prior to July, 1995." *Id.*

The VA physicians were asked to provide answers to specific questions. These questions included:

> Did VA fail, during a period of VA treatment, to diagnose the disorder which caused the veteran's death, when a physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment?

R. at 1205. In addition, the physicians were asked to determine, to the extent that VA failed to diagnose the veteran's cancer, whether the veteran suffered additional disability or death as a result of that failure. R. at 1220. In response to these questions, the VA physicians stated:

> There are no symptoms recorded during the episodes of VA treatment suggestive of a medical condition that warranted further investigation. In the absence of a history to suggest a disorder other than the multiple strokes, and in the absence of a change in physical findings to suggest a new or worsening process, further investigative studies were not clinically indicated.

Id. Further, the physicians noted:

> It is impossible to say if [the veteran] could have been cured if the disease had been detected earlier. Death from extensive small

> cell carcinoma with brain involvement usually, but not always, results in death within 10 months. Any individual patient, however, may not follow this statistic. Small cell carcinomas have a median survival with treatment of 10 months.

R. at 1221.

The Board issued the decision on appeal in September 2005. R. at 1-17. After weighing the evidence of record, including the July 2003 VA medical opinion, Dr. Pritchard's January 1998 opinion, as well as the appellant's own lay statements, the Board concluded that there was "no evidence of record suggesting that VA treatment, specifically the lack of a diagnosis of the veteran's small cell carcinoma, had the effect of hastening [the veteran's] death." R. at 9. The Board also determined that entitlement to accrued benefits based on higher ratings for the veteran's service-connected foot disabilities was not warranted. R. at 15.

II. ANALYSIS

The question presented on appeal is whether and how an omission, such as an alleged failure to diagnose a condition, may be compensated under the pre-1997 version of 38 U.S.C. § 1151, which did not require a claimant to demonstrate VA negligence. In this case, it is undisputed that the veteran's small-cell carcinoma was not diagnosed by VA, but rather, was diagnosed by a private physician in August 1995.

It is also undisputed that the veteran's cancer caused his death in October 1995. Thus, the only relevant question remaining is whether the veteran's death was caused or hastened by the fact that VA did not diagnose his carcinoma two months earlier. To prevail, therefore, the appellant must establish that VA caused the veteran to suffer an injury, or an aggravation of an injury, and that this injury or aggravation resulted in the veteran's death or the hastening thereof.

The appellant argues that "VA treatment, that is, the non-diagnosis of the veteran's cancer, had the effect of hastening [the veteran's] death." Appellant's Br. at 14. The appellant further alleges that the veteran's metastatic disease was an aggravation that resulted in his death. *Id.* The Secretary contends that the appellant has not demonstrated that VA failed to diagnose the veteran's cancer or that any such failure to diagnose resulted in an additional disability or death. Secretary's Br. at 7.

A. DIC Claim

1. Legal Framework

Veterans who suffer an additional disability or death as the result of VA hospitalization, medical or surgical treatment, vocational rehabilitation, or examinations shall receive disability compensation in the same manner as if such disability or death were service connected. 38 U.S.C. § 1151 (1996). Currently, section 1151 provides that an individual seeking to

recover based on an alleged failure to diagnose must prove "carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault" on the part of VA. 38 U.S.C. § 1151(a)(1)(A) (2008). This fault requirement applies only to claims filed on or after October 1, 1997, however, because the United States Supreme Court, in *Brown v. Gardner*, 513 U.S. 115 (1994), invalidated VA's regulations interpreting section 1151 to require claimants to demonstrate VA negligence, holding that section 1151, as it then existed, could not be read to include a fault requirement. In response to *Gardner*, Congress amended the statute to make clear that VA fault is an essential element of a section 1151 claim. *See* Pub. L. No. 104-204, Title IV. § 422(a), 110 Stat. 2926 (Sept. 26, 1996). The appellant's claim, however, was received prior to October 1, 1997; therefore, the former version of the statute applies to this case. As applicable here, the statute reads, in relevant part,

> Where any veteran shall have suffered an injury, or an aggravation of an injury, as the result of hospitalization, medical or surgical treatment . . . not the result of such veteran's own willful misconduct, and such injury or aggravation results in additional disability to or the death of such veteran, disability or death compensation under this chapter . . . shall be awarded in the same manner as if such disability, aggravation, or death were service-connected.

38 U.S.C. § 1151 (1996).

2. Failure To Diagnose Under Former Section 1151

Fault notwithstanding, it is well settled that a claimant seeking compensation under the version of section 1151 that is relevant here must demonstrate "a causal connection between the 'injury' or 'aggravation of an injury' and [VA] 'hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation.'" *Gardner*, 513 U.S. at 119 (quoting 38 U.S.C. § 1151 (1996)); *see Jackson v. Nicholson*, 433 F.3d 822, 825 (Fed. Cir. 2005)[1] (holding that, under the pre-1997 version of section 1151, a claimant must demonstrate a causal connection

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[1] Under the pre-1997 version of section 1151 at issue here and in *Jackson*, a claimant is not required to demonstrate that the alleged injury or aggravation of an injury resulted from an overt act by VA. In *Jackson*, the claimant sought recovery under the pre-1997 version of 38 U.S.C. § 1151 for post-traumatic stress disorder (PTSD) that she allegedly suffered as a result of being attacked by a fellow patient while in a VA hospital. The claimant argued that the word "hospitalization" in section 1151, when read with the phrase "as a result of," must allow for compensation of an injury that results while a claimant is in a VA hospital, regardless of whether that injury was a direct result of VA action. The United States Court of Appeals for the Federal Circuit (Federal Circuit) agreed, holding that "hospitalization," as used in the pre-1997 version of section 1151, "must mean something more than actions of the VA." *Jackson*, 433 F.3d at 825. The Federal Circuit concluded that, although a causal connection is required for compensation under section 1151, "hospitalization" is not limited to actions by VA personnel. *Id.* The claimant's PTSD therefore resulted from VA hospitalization, notwithstanding the fact that VA personnel did not perpetrate the underlying attack.

between VA hospitalization and the injury or the aggravation of an injury); 38 C.F.R. § 3.358(c) (1996). Moreover, compensation is not available for the continuance or natural progress of diseases for which VA treatment was authorized. 38 C.F.R. § 3.358(b)(2). Thus, the ultimate question is whether VA could be said to have caused or hastened the veteran's death by failing to stop the natural progression of his cancer if that failure to diagnose was not negligent. Although causation is an indispensable element of any section 1151 claim, the determination of whether or how an omission, such as a failure to diagnose, caused a particular claimant additional disability is not as clear. Courts have recognized the difficulty in assessing the element of causation in cases involving an omission, such as a failure to diagnose, versus those based on a commission, or an affirmative act, that leads to clearly identifiable injuries, especially in cases involving cancer. *See Arvayo v. United States*, 766 F.2d 1416, 1419-21 (10th Cir. 1985) (noting the difficulty in identifying the cause of an injury in a case involving a failure to diagnose); *Wilson v. United States*, No. CIV 05-384-JHP, 2006 U.S. Dist. LEXIS 34310, at *14-15 (E.D. Okla. May 26, 2006) (stating that causation is particularly difficult to ascertain in cases based on an alleged failure to diagnose cancer, because "cancer is organic, and is not literally 'caused' by mistreatment or medical negligence"). The Board has previously struggled with the inherent difficulty of assessing section 1151 claims that are based on an alleged failure to diagnose. In 2001, the VA General Counsel issued an opinion, in response to a Board

request, discussing the element of causation required in a DIC claim, as set forth in the then extant implementing regulations, and how a causal link may be proved in a failure to diagnose claim under section 1151. *See* VA Gen. Couns. Prec. 05-01 (Feb. 5, 2001) (hereinafter G.C. Prec. 05-01); *see* 38 C.F.R. § 3.358(c). As noted above, the Court ordered supplemental briefing on the relevance of this General Counsel opinion to the present case. Although the Court reviews legal issues de novo, it recognizes that opinions of the General Counsel "constitute a body of experience and informed judgment." *Osman v. Peake*, 22 Vet.App. 252, 256 (2008). Ultimately, the Court accords weight to these opinions based "upon their thoroughness, reasoning, and consistency with earlier and later pronouncements on the specific issue." *Id.*; *see Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944).

Noting that compensation is not available under section 1151 for the natural progression of a disease, the General Counsel opinion begins by questioning whether this rule presents an absolute bar to DIC benefits for claims based on omissions. G.C. Prec. 05-01 at p. 5; *see* 38 C.F.R. § 3.358(b) & (c). After reviewing various common law principles, legislative histories, and relevant case law, the opinion concluded that "it would be anomalous if section 1151 were construed to exclude coverage for a disability which . . . [is] consistently and historically recognized as resulting from medical treatment." *Id.* at p. 10. In recommending that such claims be recognized based on whether a given physician exercised an ordinary

level of skill and care, the opinion proceeds to analyze the apparent disharmony of this negligence-based standard with the holding in *Gardner*. The opinion concludes that *Gardner*, in prohibiting VA from requiring a claimant to demonstrate VA fault in addition to causation, may be differentiated from an omission claim because the latter requires a showing of fault "as a necessary element of causation, rather than a separate and additional element." G.C. Prec. 05-01 at p. 11. The Court finds this logic persuasive, as the alternative would necessarily lead to the absurd result of VA insuring any and all possible infirmities not diagnosed during VA treatment. For example, a claimant being treated at a VA facility for a knee condition may seek to recover under section 1151 should VA's orthopedic surgeon fail to diagnose his liver disease. Such a result cannot be said to be reasonably contemplated by the statute.

Simply put, to prevail under the former version of section 1151, a claimant need only demonstrate that the veteran (1) was injured, or had an injury aggravated, as the result of VA hospitalization, medical or surgical treatment and (2) that the injury or aggravation caused additional disability or death. In a failure to diagnose claim under section 1151, the "injury, or an aggravation of an injury," must necessarily be the failure to diagnose the condition. *See Brown v. District of Columbia*, 853 A.2d 733, 739 (D.C. 2004) (holding that the injury in a failure to diagnose case is the "worsening or deterioration of the plaintiff's condition that results from the physician's

failure to diagnose the patient's medical condition"); *Augustine v. United States*, 704 F.2d 1074, 1078 (9th Cir. 1983) ("the injury is the *development* of the problem into a more serious condition which poses greater danger to the patient") (emphasis in original); *Wilson*, 2006 U.S. Dist. LEXIS 34310, at *13 (discussing the plaintiff's injury as the failure to diagnose). Before proving causation, therefore, a claimant must show the existence of an injury. Taking into account the reasoning of G.C. Prec. 05-01, in a claim based on an alleged failure to diagnose, a claimant cannot demonstrate an injury unless it is shown that VA should have diagnosed the condition in question. Upon successfully demonstrating an injury or aggravation, a claimant must then prove that the injury or aggravation – the failure to diagnose – resulted in additional disability or death.

3. Application to Present Case

A Board determination regarding entitlement to compensation under section 1151 is a finding of fact. *See Look v. Derwinski*, 2 Vet.App. 157, 161-62 (1992). Similarly, a Board determination concerning the degree of disability under the rating code is a finding of fact. *Johnston v. Brown*, 10 Vet.App. 80, 84 (1994); *see also Gilbert v. Derwinski*, 1 Vet.App. 49, 53 (1990). The Court reviews Board findings of fact under the "clearly erroneous" standard of review set forth in 38 U.S.C. § 7261(a)(4). Under this standard, the Court may not reverse a Board finding of fact unless the Court, in reviewing all the evidence of record, "'is left

with the definite and firm conviction that a mistake has been committed.'" *Gilbert*, 1 Vet.App. at 52 (quoting *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948)). When applying this standard, "'[i]f the [Board's] account of the evidence is plausible in light of the record viewed in its entirety, the [Court] may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently.'" *Id.* at 52 (quoting *Anderson v. City of Bessemer City*, 470 U.S. 564, 573-74 (1985)); *see Mariano v. Principi*, 17 Vet.App. 305, 313 (2003) (applying "clearly erroneous" standard to assess, as directed by 38 U.S.C. § 7261(b)(1), the Board's application of the 38 U.S.C. § 5107(b) "equipoise standard").

Here, the Board was correct in determining that the appellant's contentions are not supported by the evidence of record. In its decision, the Board noted that Dr. Pritchard's opinion was equivocal regarding whether the veteran's cancer was diagnosable during the months preceding his actual diagnosis. R. at 9, 1048. The Board further noted that Dr. Pritchard's opinion did not assert that any alleged failure to diagnose by VA had resulted in the veteran's death. R. at 9. In contrast, the Board found that the July 2003 VA medical opinion, which was based on a review of the relevant treatment records, concluded that VA did not fail to diagnose the veteran's small-cell carcinoma because, at the time of the veteran's VA treatment, there existed no empirical evidence to warrant any clinical investigation into whether he was suffering

from cancer. R. at 9, 1218-20. In light of this VA medical opinion, the Board found that there was "no evidence of record suggesting that VA treatment, specifically the lack of a diagnosis of the veteran's small cell carcinoma, had the effect of hastening his death." R. at 9.

The Board also discussed the appellant's testimony concerning her observation of the veteran's allegedly worsening symptoms, determining that the appellant was not competent to testify as to "medical causation." R. at 9. The Board's characterization of the appellant's ability to testify about the onset of a specifically diagnosed disability, without the benefit of a medical diagnosis, is consistent with this Court's prior decisions holding that laypersons are not competent to testify about medical opinions or the etiology of medical conditions. *See Barr v. Nicholson*, 21 Vet.App. 303, 307 (2007); *see also Grover v. West*, 12 Vet.App. 109, 112 (1999). In July 1998, nearly three years after the veteran's death, the appellant stated that she had observed the veteran's health deteriorate, stating that he had experienced weight loss, loss of appetite, and slurred speech. Appellant's Br. at 6; R. at 1209. Although these conditions are medical symptoms readily observable by a layperson, the appellant is not qualified to testify as to the etiological significance of these symptoms. *See Barr, supra*. Therefore, the Board was correct in concluding that the appellant's observations lack probative value as to the question of diagnosing her husband's cancer.

In short, the appellant has not shown that VA should have diagnosed the veteran's cancer prior to his actual diagnosis. Accordingly, the Court holds that the Board's determination that the preponderance of the evidence was against the appellant's claim of entitlement to DIC benefits under 38 U.S.C. § 1151 is supported by a plausible basis in the record and is not clearly erroneous.

4. Appellant's Other Arguments

The appellant also argues that the VA medical opinion was inadequate. Appellant's Br. at 18. First, she contends that the Board erred by requesting that the VA physicians render their medical opinion based on a negligence or fault standard. Appellant's Br. at 18. As noted above, however, the medical opinion merely discusses whether VA's failure to diagnose the veteran's cancer resulted in the veteran's death, or the hastening thereof, and not whether VA exercised any particular standard of care. R. at 1218-1220. Therefore, because the VA medical opinion discussed causation and not fault, and because causation is a necessary element in a section 1151 claim, the VA medical opinion was not inadequate.

Second, the appellant asserts that the opinion was inadequate because the examiners failed to consider evidence that supported her claim. Appellant's Br. at 18. The appellant's argument is not supported by this Court's jurisprudence or the governing statutory law. A medical examiner need not

discuss all evidence favorable to an appellant's claim when rendering an opinion. To be adequate, a medical opinion must be based on a consideration of the veteran's prior history and examinations and describe the veteran's condition in sufficient detail so that the Board's evaluation of the claim may be fully informed. *Stefl v. Nicholson*, 21 Vet.App. 120, 123 (2007); *see Moore v. Nicholson*, 21 Vet.App. 211, 218 (2007) ("'It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present.'" (quoting 38 C.F.R. § 4.2)). Here, as noted, the VA opinion was based on a full review of the veteran's medical records and the VA physicians' opinion was sufficiently detailed to allow for a fully informed Board decision.

B. Accrued Benefits Claim

With regard to her accrued benefits claim, the appellant argues that the Board failed to provide an adequate statement of reasons or bases for its decision not to assign higher ratings for the veteran's service-connected foot disabilities. Appellant's Br. at 25. She also contends that, because this matter was previously before the Court, the Board failed to comply with the Court's remand order directing it to provide an adequate statement of reasons or bases for its decision. *Id.*; *see Stegall v. West*, 11 Vet.App. 268 (1998). Specifically, the appellant contends that the

Board erred in not explaining why all of the veteran's foot symptomatologies are not covered in his ratings. Appellant's Br. at 26.

In this case, the Board thoroughly discussed the applicable rating criteria and relevant evidence of record. *See* R. at 10-14. The Board reviewed the evidence and provided adequate reasons or bases for its determination that higher ratings were not warranted for the veteran's foot disabilities, clearly explaining its conclusion that the symptoms reported by the veteran indicated that a 10% rating was correct. Although the appellant argues that the Board's decision did not adequately explain certain evidence, she does not indicate or present reasons why she believes that "certain evidence" was relevant. It is well established that the Board need not discuss all of the evidence of record so long as it addresses the relevant evidence. *See Dela Cruz v. Principi*, 15 Vet.App. 143, 149 (2001) (Board not required to discuss all of the evidence of record but must discuss *relevant* evidence); *Schafrath v. Derwinski*, 1 Vet.App. 589, 593 (1991) (Board must discuss, inter alia, all *relevant* evidence). As the Secretary correctly notes in his brief, the Board discussed the appellant's weakness on his right side as well as the bilateral degenerative changes. Secretary's Br. at 13; R. at 12-13. The Board decision describes, in detail, the veteran's various symptomatologies in light of limitation of motion, interference with employment status, and frequency of hospitalization. R. at 13-14. As the Board fully articulated the

reasons or bases for its findings, and because its determination was plausibly based on all of the evidence of record, we hold that the Board's decision on the rating to be assigned was not clearly erroneous. *See* 38 U.S.C. § 7261(a)(4); *Hersey v. Derwinski*, 2 Vet.App. 91 (1992) (the Court may not substitute its judgment for Board merely because it would have decided the issue differently).

III. CONCLUSION

After the Court's consideration of the appellant's and the Secretary's briefs, its review of the record, and its consideration of the parties' positions advanced at oral argument, the September 21, 2005, decision of the Board is AFFIRMED.

Not published

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No: 05-3243

CATHERINE ROBERSON, Appellant

v.

ERIC K. SHINSEKI,
Secretary of Veterans Affairs, Appellee

JUDGMENT

The Court has issued a decision in this case. The time allowed for motions under Rule 35 of the Court's Rules of Practice and Procedure has expired.

Under Rule 36, judgment is entered this date.

Dated: March 3, 2009

FOR THE COURT:

Norman Y. Herring
Clerk of the Court

By: /s/ Joan E. Sayers
Deputy Clerk

Copies to:
VA General Counsel (027)
Sandra E Booth, Esq.

Department of Veterans Affairs **Memorandum**

Date: February 5, 2001 VAOPGCPREC 5-2001

From: General Counsel (022)

Subj: Application of 38 U.S.C. § 1151 to Claims Based on VA Failure to Diagnose Pre-Existing Condition

To: Chairman, Board of Veterans' Appeals (01)

QUESTIONS PRESENTED:

a. For claims filed after November 25, 1991, and before October 1, 1997, does 38 U.S.C. § 1151 authorize compensation for additional disability alleged to have resulted from the omission or failure by the Department of Veterans Affairs (VA) to diagnose or treat an underlying disease or injury, or does section 1151 authorize compensation only for disability resulting from an act of commission by VA?

b. If section 1151 authorizes compensation, with respect to claims filed during that time period, based on VA's omission or failure to diagnose or treat an underlying disease or injury, what are the essential elements of such a claim that must be established in order for a claimant to prevail?

DISCUSSION:

1. In the case giving rise to the opinion request, the veteran was examined at a VA outpatient clinic in October 1994 for complaints of sharp, constant chest

pain radiating to an arm. Following examination and testing, he was diagnosed with noncardiac chest pain, and medication was prescribed. Several days later, the veteran returned to the outpatient clinic and reported that the chest pain had gone away the day after his prior visit. In January 1995, the veteran died as a result of arteriosclerotic cardiovascular disease with myocardial infarct. A county medical examiner opined that the VA physician had missed the diagnosis of arteriosclerotic cardiovascular disease and, if VA had conducted further testing in October 1994, the veteran's death may have been avoided. A VA cardiologist who reviewed the veteran's medical records stated that the veteran's complaints in October 1994 did not appear to be cardiac in nature and it was clinically reasonable to defer any further cardiac workup. The veteran's surviving spouse has filed a claim for benefits under 38 U.S.C. § 1151, asserting that VA's failure to diagnose the veteran's cardiac condition precluded appropriate treatment that would have prevented his death.

2. The current provisions of 38 U.S.C. § 1151, as amended by Pub. L. No. 104-204, apply only with respect to claims filed on or after October 1, 1997. Pub. L. No. 104-204, § 422(a) and (c), 110 Stat. 2874, 2926-27 (1996); VAOPCGPREC 40-97 (Dec. 31, 1997). Because the veteran's claim was filed prior to that date, it is governed by the provisions of 38 U.S.C. § 1151 in effect prior to October 1, 1997. All subsequent references to 38 U.S.C. § 1151 in this opinion are to the version of that statute in effect prior to

October 1, 1997. Section 1151 provides, in pertinent part:

> Where any veteran shall have suffered an injury, or an aggravation of an injury, as the result of hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation under chapter 31 of this title, awarded under any of the laws administered by the Secretary, or as a result of having submitted to an examination under any such law, and not the result of the veteran's own willful misconduct, and such injury or aggravation results in additional disability to or the death of such veteran, disability or death compensation under this chapter and dependency and indemnity compensation under chapter 13 of this title shall be awarded in the same manner as if such disability or death were service-connected.

In *Brown v. Gardner*, 513 U.S. 115, 119 (1994), the Supreme Court held that section 1151 did not impose any requirement of a showing of fault on the part of VA, but merely required that an injury[1] have been incurred or aggravated "as a result of" VA hospitalization, treatment, or other specified activities. The Court stated that the statutory language "is naturally read simply to impose the requirement of a causal connection between the 'injury' or 'aggravation of an

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[1] As used in section 1151 and in this opinion, the term "injury" includes diseases. *See* 38 C.F.R. § 3.358(a); VAOPGCPREC 1-99 (Feb. 16, 1999).

injury' and 'hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation.'" *Id.* at 119.

Applicability of 38 U.S.C. § 1151 to Claims Based on "Acts of Omission"

3. The first question presented in the opinion request asks whether section 1151 authorizes compensation for disability allegedly resulting from VA's failure to diagnose or treat an existing disease or injury or whether the statute permits compensation only for disability resulting from an affirmative act of commission by VA. The language of section 1151 does not suggest any intent to draw a distinction between acts of commission and acts of omission. We are aware of no legal basis for concluding categorically that an act of omission may not, in any circumstance, be found to have caused or aggravated an injury. It is at least possible that VA's failure to take a particular action with respect to a person under VA's care may result in injury or aggravation of an injury. Accordingly, the plain language of section 1151 would authorize payment of benefits whenever it is found that an injury was caused or aggravated by VA hospitalization, medical or surgical treatment, examination, or vocational rehabilitation, regardless of whether the incident causing the injury may be characterized as involving an act of commission or omission.

4. We have found nothing in the legislative history of section 1151 to suggest an intent to distinguish

between acts of commission and acts of omission. The history of section 1151 is discussed in detail in *Gardner v. Brown*, 5 F.3d 1456, 1460-62 (Fed. Cir. 1993), *aff'd*, 513 U.S. 115 (1994), and need not be repeated in full here. Provisions authorizing benefits for injuries incurred or aggravated as a result of VA hospitalization, treatment, and examination were originally enacted by section 213 of the World War Veterans' Act of 1924, ch. 320, 43 Stat. 607, 623 (1924) (WWVA). We note that, in the debates preceding enactment of the WWVA, Congress expressed concern that certain VA procedures, such as spinal punctures (used as a diagnostic procedure), had caused injury to persons receiving VA medical care. *See World War Veterans' Legislation: Hearings Before the House Comm. on World War Veterans' Legislation*, 68th Cong., 1st Sess. 114 (1924). Although the specific incidents discussed in those debates appear to have involved what may be characterized as acts of commission by VA, the discussion of those specific circumstances, by way of example, does not suggest an intent to authorize compensation only in those specific circumstances.

5. Two VA Administrator's Decisions have characterized section 1151 and its predecessors as authorizing compensation in claims based on acts of omission by VA. In Administrator's Decision No. 944 (July 26, 1954), the issue addressed was whether compensation was payable under section 31 of Pub. L. No. 73-141, 48 Stat. 509 (1934), a predecessor of section 1151, for injury or death sustained while a VA patient was

being transported from one VA hospital to another VA hospital. The Administrator's Decision held that, if the injury sustained by a hospitalized patient proximately resulted from "negligence (or other wrongful act or omission)" by agents of VA, disability or death resulting from such injury would be compensable. Administrator's Decision No. 992 (Dec. 14, 1970) stated that 38 U.S.C. § 351 (now § 1151) had been construed to mean that injury or aggravation of injury must have resulted from "negligence or wrongful act or omission" by an agent or employee of VA, as distinguished from such negligence, wrongful act, or omission by an independent contractor. Those decisions suggest that VA has not previously construed section 1151 or its predecessors as excluding from its scope claims based on VA omissions, as distinguished from acts of commission.

6. We note also that the distinction between omissions and acts of commission is not entirely clear and it is possible that some circumstances – e.g., the failure to properly sterilize a wound during surgery – could perhaps be characterized as either omissions or acts of commission. However, because nothing in section 1151 suggests a need to distinguish between acts of commission and acts of omission, we need not address whether it is possible to state an intelligible distinction between the two. Based on the plain language of the statute, we conclude that 38 U.S.C. § 1151 authorizes compensation without regard to whether the circumstances causing or aggravating

the injury in question may be characterized as omissions or acts of commission.

Causation Requirement Under 38 U.S.C. § 1151

7. The foregoing conclusion does not fully resolve the question of whether section 1151 authorizes compensation for disability or death due to failure to diagnose or treat an existing disability. Section 1151 requires that the veteran have "suffered an injury, or an aggravation of an injury, as the result of" VA hospitalization, treatment, or examination. Thus, it must be determined that the VA hospitalization, treatment, or examination caused an injury or aggravation of an injury. *See Gardner*, 513 U.S. at 119. As applied to claims based on a failure to diagnose or treat a preexisting condition, this causation requirement is susceptible of two different interpretations, as discussed below.

8. It is well established that the causation requirement generally precludes payment of benefits for the natural consequences of a preexisting condition. *See* 38 C.F.R. § 3.358(b)(2) ("Compensation will not be payable under 38 U.S.C. 1151 for the continuance or natural progress of the disease or injuries for which the training, or hospitalization, etc., was authorized"). In *Gardner*, the Supreme Court stated that it did not "intend to cast any doubt on [VA's] regulations insofar as they exclude coverage for incidents of a disease's or injury's natural progression, occurring after the date of treatment." 513 U.S. at 120 n.3. A

claim based on a failure to diagnose or treat a pre-existing condition is, in essence, a claim that VA caused or aggravated an injury merely by failing to prevent the natural consequences of the preexisting condition. Accordingly, it may be plausible to conclude that such claims are precluded by the plain language of section 1151.

Common Law Principles of Causation

9. On the other hand, it is well established, in the common law[2] relating to medical malpractice claims, that a negligent failure to diagnose or treat a pre-existing condition may be viewed as the legal cause of any consequences of such condition that would have been prevented by proper diagnosis or treatment. *See* John D. Hodson, Annotation, *Medical Malpractice: "Loss of Chance" Causality*, 54 A.L.R. 4th 10 (1987) (citing cases from 37 states and District of Columbia). In tort claims, as in section 1151, a claimant generally must establish that he or she suffered an injury as a result of the other party's conduct. *See* 61 Am. Jur. 2d *Physicians, Surgeons and Other Healers*, § 359 (1981). Legal commentators have

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[2] "Common law" refers to the body of law derived from judicial decisions rather than statutes. BLACK'S LAW DICTIONARY 270 (7th ed. 1999). Principles of liability for negligence, including medical malpractice, developed primarily through the common law, although they have been modified in various jurisdictions by statute. *See* 57A Am. Jur. 2d *Negligence* § 3 (1989).

noted that determinations concerning injury and causation are often complicated in the context of medical malpractice claims by the fact that the "injury" complained of may be viewed as a result of the claimant's preexisting disability. *See* Hodson, 54 A.L.R. 4th at 17; LOUISELL, DAVID W. & WILLIAMS, HAROLD, MEDICAL MALPRACTICE, ¶ 8.07, at 8-82 to 8-83 (2000). In addressing this difficulty, courts have generally relied on the principle that physicians owe their patients a duty of skill and care in the diagnosis and treatment of disease and injury. *See* 61 Am. Jur. 2d *Physicians, Surgeons and Other Healers*, §§ 200-202, 248 (1981). Accordingly, where a physician fails to exercise the requisite degree of care in diagnosing and treating an existing condition, the physician's actions may be viewed as the proximate cause of the disability or death that would have been prevented by proper care. *See Id.* § 248; W.E. Shipley, Annotation, *Proximate Cause in Malpractice Cases*, 13 A.L.R. 2d 11, §§ 2, 28 (1950). However, a failure to diagnose or treat a preexisting condition is not considered the cause of subsequent disability or death if the physician exercised the degree of skill and care ordinarily required of the medical profession. *See* 61 Am. Jur. 2d *Physicians, Surgeons and Other Healers*, § 248.

Application of Common Law Principles to Claims Under 38 U.S.C. § 1151

10. Claims under section 1151 and medical malpractice claims both require determinations as to whether an injury was caused by some act or omission

associated with medical treatment. Accordingly, it may be reasonable to conclude that Congress intended determinations of causation under section 1151 to be governed by the established common-law principles of causation developed in the context of medical malpractice claims. Section 1151 authorizes compensation for disability or death due to injury incurred or aggravated "as the result of" VA hospitalization, treatment, or examination. The phrase "as the result of" is commonly understood to refer to the legal concept of causation. *See Gardner*, 513 U.S. at 119; *Funseth v. Great Northern Ry. Co.*, 399 F.2d 918, 922 (9th Cir. 1968), *cert. denied*, 393 U.S. 1083 (1969). Causation, as it relates to claims of injury due to medical treatment, is a familiar legal concept which has developed an established common-law meaning through many years of judicial interpretation. The Supreme Court has stated that "'where Congress borrows terms of art in which are accumulated the legal tradition and meaning of centuries of practice, it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken and the meaning its use will convey to the judicial mind unless otherwise instructed.'" *Evans v. United States*, 504 U.S. 255, 259 (1992) (quoting *Morisette v. United States*, 342 U.S. 246, 263 (1952)). Under this standard, it may be presumed that, in enacting a statute relating to injury incurred "as a result of" VA treatment, Congress intended to incorporate the common-law principles traditionally applied to determine whether an injury was caused by medical treatment.

11. The provisions of section 1151 were enacted in 1958 by Pub. L. No. 85-857, § 351, 72 Stat. 1105, 1124 (1958). Prior provisions employing similar language have existed since 1924. *See* WWVA § 213, 43 Stat. at 623; Act of March 28, 1934, ch. 102, § 31, 48 Stat. 509, 526 (1934 Act) (essentially reenacting the WWVA provision that had been repealed in 1933). The principle that a negligent failure to diagnose and/or treat an existing condition may be viewed as the legal cause of disability that would have been prevented by proper treatment was apparently well established prior to even the earliest of these statutes. *See* Shipley, *Proximate Cause in Malpractice Cases*, 13 A.L.R. 2d 11, § 28 (collecting cases based on failure to diagnose); *Brewer v. Ring*, 99 S.E. 358, 364 (N.C. 1919) ("'The law is, of course, well settled that a physician is liable for wrong diagnosis of a case, resulting from a want of reasonable skill or care on the part of the physician, and followed by improper treatment, to the injury of the patient.'") (quoting *Just v. Littlefield*, 151 P. 780, 781 (Wash. 1915)); *Manser v. Collins*, 76 P. 851, 853 (Kan. 1904) ("It may be said that the failure of the doctor to alleviate the patient's suffering was the cause of it, at least, to the excess above the minimum to which it might have been reduced after prompt discovery of the cause and by proper treatment.").

12. In view of the above-referenced authorities, the language of section 1151 does not, in our view, clearly answer the question of whether benefits may be paid based on VA's failure to diagnose or treat a

preexisting condition. Although it may be argued that a literal reading of the statutory language precludes compensation under any circumstances for the natural consequences of a preexisting condition, an equally plausible argument can be made that causation language in the statute must be presumed to incorporate the established common-law principles of causation discussed above.

13. The legislative history of section 1151 and its predecessors also does not resolve this issue, as it contains no reference to claims based on the failure to diagnose or treat a preexisting condition. Notably, however, the legislative discussion preceding the 1934 Act indicates a purpose "to protect the men who suffer from malpractice at the hands of [VA] physicians." 78 Cong. Rec. 3289 (Feb. 27, 1934) (statement of Sen. Steiwer). Although the Supreme Court's *Gardner* opinion held that section 1151 is not limited to cases of malpractice, this legislative history suggests that cases of malpractice would be covered by section 1151. Additionally, the reference to malpractice is consistent with the presumption, discussed above, that Congress intended to incorporate common-law tort principles of causation, to the extent applicable to section 1151 claims. *See Evans*, 504 U.S. at 259.

14. We conclude that section 1151 is most reasonably construed as authorizing benefits where VA improperly fails to diagnose or provide treatment for a preexisting disease, if it is determined that the veteran's disability is greater than it would have been with proper diagnosis and treatment. In addition to

the legislative history discussed above, there are several reasons why this interpretation is, in our view, more reasonable than an interpretation which would preclude payment of benefits under those circumstances.

15. First, we believe this interpretation is more consistent with VA's historical construction of section 1151 and its predecessors than the alternative interpretation. Veterans' Bureau regulations implementing section 213 of the WWVA provided that "[c]ompensation . . . will not be paid for the ordinary residuals of disease or injury following *accepted* medical treatment nor for the continuation of the original disability where improvement cannot be effected by *approved* medical or surgical treatment." " Veterans' Bureau Regulation No. 137, § 7701 (June 26, 1926) (emphasis added). The underlined terms imply that compensation may have been payable for the residuals of a preexisting condition where VA failed to follow accepted practices which would have prevented such residuals. This regulation was amended in 1927 to provide that compensation would not be paid for "[t]he usual after results of approved medical care and treatment properly administered." Veterans' Bureau Regulation No. 167, § 7701.B(4). The reference to the results of "properly administered" care continued the implication that compensation could be paid for results of improper care. However, the 1927 regulation also provided that compensation would not be paid for "the continuance or natural progress of diseases or injuries for which

the training, hospitalization, etc., was authorized." *Id.* at § 7701.B(2).

16. As reflected in *Gardner*, VA's regulations have consistently authorized benefits under section 1151 in cases of disability or death attributable to VA's fault or negligence. Similarly, as noted above, Administrator's Decisions in 1954 and 1970 defined the scope of section 1151 and its predecessors with reference to common-law principles of negligence. *See* Administrator's decision No. 992 (Dec. 14, 1970); Administrator's Decision No. 944 (July 26, 1954). Although VA has not previously addressed the particular issue discussed in this opinion, its long-standing interpretation of section 1151 is consistent with the view that benefits may be paid in circumstances which would ordinarily give rise to malpractice liability in the context of tort claims.

17. The Supreme Court's opinion in *Gardner* also appears to acknowledge the propriety of applying tort-law principles in making determinations concerning causation and injury under section 1151. The Court indicated that applying the tort principle of *volenti non fit injuria* (i.e., consent to necessary consequences of treatment) would accurately reflect the legislative intent underlying section 1151. *Gardner*, 513 U.S. at 120 n.3. Additionally, the Attorney General of the United States has concluded that, insofar as section 213 of the WWVA applied to injury incurred "as the result of" vocational rehabilitation, Congress intended VA to apply the judicially-developed principles of causation from the closely

related area of worker's compensation laws. 36 Op. Atty. Gen. 61, 64 (May 17, 1929). In VAOPGCPREC 7-97 (Jan. 29, 1997), we concluded that causation standards developed in the area of worker's compensation law may also provide relevant guidance in determining whether an injury was caused by aspects of hospitalization other than medical treatment. For purposes of determining whether injury resulted from VA medical treatment or examination, application of causation principles from the closely related field of medical malpractice law would be consistent with the approach recognized by the above-referenced authorities.

18. Related to the foregoing concerns, we believe that the general import of the Supreme Court's opinion in *Gardner* is that section 1151 is intended to be more, rather than less, inclusive in scope than the liability standards governing medical malpractice claims. It would be anomalous if section 1151 were construed to exclude coverage for disability which medical malpractice law has consistently and historically recognized as resulting from medical treatment. Additionally, we note that our interpretation of section 1151 is consistent with the principle that interpretive doubt in statutes providing benefits to veterans should be resolved in the veterans' favor. *See Gardner*, 513 U.S. at 117-18.

19. In summary, interpreting section 1151 to authorize compensation for disability due to an improper failure to diagnose or treat a preexisting condition, in our view, comports most closely with the legislative

intent to provide a remedy for those injured as a result of VA treatment. Veterans who seek care from VA in lieu of treatment from other sources may reasonably expect the same degree of skill and care required of physicians generally. Inasmuch as the common law has long established the parameters of the physician's duty to his or her patients and has established standards for identifying injury and causation due to treatment, there is no reason to infer that Congress intended a different causation standard in section 1151.

Effect of Gardner Decision

20. As noted above, the common law of medical malpractice recognizes a failure to diagnose or treat a preexisting condition as the cause of subsequent disability only if the failure to diagnose or treat the condition resulted from a failure to exercise ordinary skill and care in the diagnosis and treatment. If a physician exercises the degree of skill and care ordinarily required of members of the medical profession, the fact that the physician misdiagnosed or failed to diagnose a condition cannot be viewed as the cause of subsequent disability flowing from that condition. 61 Am. Jur. 2d *Physicians, Surgeons and Other Healers*, § 248 (1981). Applying this causation standard to claims under section 1151 may appear to conflict with the Supreme Court's decision in *Gardner*, which held that section 1151 does not require a showing of VA fault in order to receive compensation under that statute. However, the Supreme Court also held that

section 1151 plainly requires a showing of a causal connection between an injury or aggravation of an injury and VA hospitalization or treatment. *Gardner*, 513 U.S. at 119. Under the common law pertaining to claims based on failure to diagnose or treat a pre-existing condition, a showing that the failure was due to the lack of ordinary care or skill is a necessary element of establishing the causal relationship between treatment and injury. Absent such a showing, there is no legal basis for concluding that the claimant's disability resulted from the treatment rendered, rather than the natural progress of the preexisting condition.

21. In *Gardner*, the Supreme Court addressed the issue of whether section 1151 permitted VA to require a showing of VA fault *in addition to* a showing that the veteran's injury was caused by VA treatment. The Court held that section 1151 imposed only a causation requirement and did not authorize VA to establish an additional requirement for a showing of fault. The Court did not, however, address the circumstance presented here, where a showing of failure to exercise ordinary skill and care is a necessary element of causation, rather than a separate and additional element of entitlement. Accordingly, *Gardner* does not, in our view, preclude VA from requiring a showing of lack of due skill or care in the limited circumstances where such a showing is necessary to establish the element of causation. *See Landgraf v. USI Film Products*, 511 U.S. 244, 265 (1994) (quoting *Cohens v. Virginia*, 19 U.S. (6 Wheat.) 264, 399

(1821)) ("'general expressions, in every opinion, are to be taken in connection with the case in which those expressions are used'"). As noted above, absent a showing of lack of due skill or care, there would be no legal basis for concluding that VA treatment caused the veteran's disability or death, and VA would have no authority under section 1151 to pay compensation for such disability or death. Accordingly, in this circumstance, application of a fault-based standard is actually more favorable to veterans than the alternative and is consistent with the principle that interpretive doubt should be resolved in favor of veterans.

22. We emphasize that our conclusion does not negate the conclusion stated in 38 C.F.R. § 3.358(b)(2) that section 1151 generally does not authorize compensation for the natural consequences of a preexisting condition. Rather, our conclusion merely reflects the common-law rule that the failure to exercise proper care in the diagnosis and treatment of a preexisting condition may be viewed as the cause of any disability that would have been prevented by proper treatment. Absent a showing that VA failed to exercise ordinary skill and care, or absent a showing that the disability or death would have been prevented by proper treatment, the rule in section 3.358(b)(2) will govern.

Elements of Claim Based on Failure to Diagnose or Treat a Preexisting Condition

23. The second issue presented in the opinion request concerns the elements necessary to establish entitlement to benefits under section 1151 based on a claim that VA failed to diagnose or treat a preexisting condition. Although the factual showing necessary to substantiate a claim may vary depending upon the facts of each case and the nature of the alleged injury and cause, we believe that guidance may be drawn from the case law addressing the issue of causation in the context of malpractice claims. The general principles of causation are summarized in a number of legal treatises. *See, e.g.,* 61 Am. Jur. 2d *Physicians, Surgeons and Other Healers*, §§ 248, 359 (1981); LOUISELL & WILLIAMS, MEDICAL MALPRACTICE, ¶ 8.07; 70 C.J.S. *Physicians and Surgeons* § 72 (1987). Under these standards, entitlement to benefits based on a claim of failure to diagnose or treat a preexisting condition would ordinarily require a determination that: (1) VA failed to diagnose and/or treat a preexisting disease or injury; (2) a physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment; and (3) that the veteran suffered disability or death which probably would have been avoided if proper diagnosis and treatment had been rendered.

24. With respect to the second element referenced above, courts have held that medical evidence is ordinarily required in order to establish that a

physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment. *See* LOUISELL & WILLIAMS, MEDICAL MALPRACTICE, at ¶¶ 8.04[3], 8.07[4]. Determinations as to whether a physician's diagnosis, treatment, or procedures for arriving at a diagnosis or course of treatment conform to ordinary standards of medical care generally present matters outside the ordinary knowledge of laypersons and, therefore, must be shown by medical evidence. *Id.* at ¶ 8.04[3][a]. An exception to this requirement is recognized, however, where the alleged failure to exercise ordinary skill and care is one which would be readily apparent to a layperson. *Id.* at ¶ 8.04[3][b]. We note that VA may assist claimants by obtaining a medical opinion on this issue when deemed necessary to adjudication of a claim. *See* 38 U.S.C. § 5103A.

25. With respect to the third element referenced above – i.e., proof that disability or death would have been prevented by proper treatment – courts have generally held that the failure to diagnose or treat a condition may be viewed as the cause of subsequent disability only if it is probable, or more likely than not, that the disability would have been avoided by proper diagnosis and treatment. *See* LOUISELL & WILLIAMS, MEDICAL MALPRACTICE, at ¶¶ 8.07[2], Hodson, *Medical Malpractice: "Loss of Chance" Causality*, 54 A.L.R. 4th at 18. If the disability would not have been prevented in any event, the physician's failure to diagnose or treat the preexisting condition

cannot be viewed as the cause of the disability. Some courts have held that tort liability may be imposed merely where the physician's failure to diagnose or treat a condition resulted in the loss of some chance for a better result, even if it cannot be shown that the resulting disability probably would have been avoided by proper diagnosis and treatment. *See* Hodson, *Medical Malpractice: "Loss of Chance" Causality*, 54 A.L.R. 4th at 18-22, 34-41. This standard, however, would be inconsistent with the requirement in section 1151 that the injury or aggravation of the injury have occurred "as the result of" VA treatment. Absent a basis for concluding that the disability or death probably would have been avoided by proper diagnosis and treatment, it would be wholly speculative to conclude that VA treatment was the cause of the disability or death. *See Crosby v. United States*, 48 F. Supp. 2d 924, 928, 931 (D. Alaska 1999) ("loss of chance" theory is inconsistent with statute requiring causal connection between treatment and injury). Of course, in determining whether proper diagnosis and treatment probably would have prevented subsequent disability or death, the benefit of the doubt rule in 38 U.S.C. § 5107(b) should be applied when applicable.

HELD:

a. Under the provisions of 38 U.S.C. § 1151 applicable to claims filed prior to October 1, 1997, benefits may be paid for disability or death attributable to VA's failure to diagnose and/or treat a pre-existing condition when VA provides treatment or

an examination. Disability or death due to a pre-existing condition may be viewed as occurring "as a result of the VA treatment or examination only if a physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment which probably would have avoided the resulting disability or death.

b. The factual elements necessary to support a claim under section 1151 based on failure to diagnose or treat a preexisting condition may vary with the facts of each case and the nature of the particular injury and cause alleged by the claimant. As a general matter, however, entitlement to benefits based on such claims would ordinarily require a determination that: (1) VA failed to diagnose and/or treat a pre-existing disease or injury; (2) a physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment; and (3) the veteran suffered disability or death which probably would have been avoided if proper diagnosis and treatment had been rendered.

John H. Thompson

Attachment: Claims File

SUBCHAPTER VI.
GENERAL COMPENSATION PROVISIONS

38 USCS § 1151. Benefits for persons disabled by treatment or vocational rehabilitation

Where any veteran shall have suffered an injury, or an aggravation of an injury, as the result of hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation under chapter 31 of this title [38 USCS §§ 3100 et seq.], awarded under any of the laws administered by the Secretary or as a result of having submitted to an examination under any such law, and not the result of such veteran's own willful misconduct, and such injury or aggravation results in additional disability to or the death of such veteran, disability or death compensation under this chapter [38 USCS §§ 1101 et seq.] and dependency and indemnity compensation under chapter 13 of this title [38 USCS §§ 1301 et seq.] shall be awarded in the same manner as if such disability, aggravation, or death were service-connected. Where an individual is on or after December 1, 1962 awarded a judgment against the United States in a civil action brought pursuant to section 1346(b) of title 28, or on or after December 1, 1962 enters into a settlement or compromise under section 2672 or 2677 of title 28, by reason of a disability, aggravation, or death treated pursuant to this section as if it were service-connected, then no benefits shall be paid to such individual for any month beginning after the date of such judgment, settlement, or compromise on

account of such disability, aggravation, or death becomes final until the aggregate amount of benefits which would be paid but for this sentence equals the total amount included in such judgment, settlement, or compromise.

(Sept. 2, 1958, P. L. 85-857, § 1, 72 Stat. 1124; Oct. 15, 1962, P. L. 87-825, § 3, 76 Stat. 950; June 11, 1969, P. L. 91-24, § 3, 83 Stat. 33; Sept. 30, 1976, P. L. 94-433, Title IV, § 404(19), 90 Stat. 1379; March 2, 1984, P. L. 98-223, Title II, § 213(1), 98 Stat. 46; Aug. 6, 1991, P. L. 102-83; §§ 4(a)(1), 5(a), 105 Stat. 406.)

RIVERSIDE METHODIST HOSPITALS
3535 OLENTANGY RIVER ROAD
COLUMBUS, OHIO 43214
a U.S. Health Affiliate

ROBERSON, ISAAC JR Richard B. Esler, D.O.
M.R.# 00505302 ER 03002400889

EMERGENCY DEPARTMENT
PHYSICIAN NOTE

DATE OF PRESENTATION: 08/14/95

TIME DICTATED: 12:21 A

CHIEF COMPLAINT: Vomiting and lethargy.

HISTORY OF PRESENT ILLNESS: This is a 60 year old male who was a transfer from Northland Terrace. He apparently has been having decreased mental status over the last week. Over the last two to three days, he has been vomiting profusely. His history is very sketchy. It is difficult to interpret the material that has come from the extended care facility. He does have a history of multiple cerebral infarcts. He also has a history of a carcinoma of the prostate with probable metastasis. He denies any pain, but he is very difficult to get any significant history.

PAST MEDICAL HISTORY: Positive for hypertension, gout, carcinoma of the prostate, and multiple CVAs.

FAMILY HISTORY: Unknown.

SOCIAL HISTORY: Unknown.

CURRENT MEDICATIONS: Allopurinol, Ticlid, Naprosyn, Prinivil, Hydrochlorothiazide, Procardia, Colace.

ALLERGIES: Unknown.

REVIEW OF SYSTEMS: Unknown.

PHYSICAL EXAMINATION: This is a 60-year-old male who will arouse to verbal and painful stimuli. He answers inappropriately. Very difficult to get a neurological assessment because of noncooperation. He poorly moves all extremities. Eyes, ears, nose, and throat show dry oral mucous membranes. Neck is appropriately supple. Chest has rhonchi bilaterally. Heart is regular with an apical rate of 80. Abdomen is unremarkable soft. He does have bowel sounds present. His stool is hemoccult negative. Extremities are grossly unremarkable.

DIAGNOSTIC TEST RESULTS: His chemistry profile shows his creatinine to be 2.2. His urinalysis was unremarkable. It was negative for any ketones. CBC shows a white count of 10,400. Hemoglobin is 11.9, hematocrit 36.1. His EKG shows a sinus tachycardia with a rate of 121. He has an interventricular conduction defect, nonspecific STT wave changes. CT of the head was done without contrast because of his renal function. It showed multiple old infarcts present. There was a question of a metastatic area in the posterior fossa.

EMERGENCY DEPARTMENT COURSE: He had an IV of normal saline. The care was discussed with Dr. Moore, who was covering for Dr. Smith

CLINICAL IMPRESSION: Mental status changes, rule out a prostatic carcinoma with cerebral metastasis.

TREATMENT PLAN/DISPOSITION: Admit to Dr. Andrew Smith to a General Medical Bed.

/s/ Richard Esler
Richard B. Esler, D.O.

D: 08/15/95
T: 08/15/95 12:34 A / ejr / 77

DEPARTMENT OF RADIATION/ONCOLOGY
RIVERSIDE METHODIST HOSPITALS
COLUMBUS, OHIO

CONSULTATION NOTE
DATE: 8/30/95
ROOM: 4122

RE: ROBERSON, ISAAC JR.
DOB: 7/22/35

REFERRING PHYSICIAN: JANET BAY M.D.

DIAGNOSIS: BRAIN METASTASES

HISTOLOGY: SMALL CELL UNDIFFERENTIATED CARCINOMA

HISTORY: 60 YOBM PRESENTS WITH ALTERED MENTAL STATUS. HE WAS PREVIOUSLY WORKED UP FOR A CVA. HEAD CT SHOWED AN OLD INFARCT, BUT NO EVIDENCE OF MALIGNANCY. SYMPTOMS WORSENED AND REPEAT HEAD CT SUGGESTED BRAIN METASTASIS WITH OBSTRUCTIVE HYDROCEPHALUS. MRI CONFIRMED A LARGE POST FOSSA MASS WITH OBSTRUCTIVE HYDROCEPHALUS ADDITIONAL WORKUP REVEALED MULTIPLE SUBCUTANEOUS METASTASES, POSSIBLE RIGHT APICAL LUNG MASS, BUT NO HILAR OR MEDIASTINAL ADENOPATHY AND MULTIPLE RETROPERITONEAL AND PERITONEAL MASSES ADRENAL METASTASES ARE NOTED BILATERALLY. EXTENSIVE METASTATIC LIVER DISEASE MEASURING UP TO 9 CM. WAS ALSO NOTED. PLAIN CT SUGGESTED POSSIBLE BONE METASTASES AS DID A KUB. BIOPSIES SHOWING SMALL CELL UNDIFFERENTIATED CARCINOMA.

HE IS CURRENTLY IN THE ICU WITH PERSISTENT ALTERED MENTAL STATUS. CHEMOTHERAPY WAS INITIALLY DECLINED, BUT HIS WIFE WAS NOT ANXIOUS TO INITIATE AGGRESSIVE COMBINED MODALITY THERAPY.

ON EXAMINATION: HE IS A SOMNOLENT BLACK MALE IN NAD. HE HAS MULTIPLE SUBCUTANEOUS NODULES THROUGHOUT THE INTEGUMENT. LUNG FIELDS ARE REMARKABLY CLEAR. CARDIAC EXAM IS UNREMARKABLE. HE HAS PALPABLE ABDOMINAL MASSES OR HEPATOMEGALY TO PERCUSSION. EXTREMITIES SHOW NO EDEMA. NEUROLOGIC EXAM WAS LIMITED. BABINSKI'S ARE UPGOING. DETAILED TESTING COULD NOT BE PERFORMED.

COMMENTS: HE HAS WIDESPREAD METASTATIC SMALL CELL UNDIFFERENTIATED CARCINOMA. I DISCUSSED THE SITUATION WITH THE PATIENT'S WIFE AND ALSO WITH HIS DAUGHTER BY PHONE FROM THE ROOM IN HIS WIFE'S PRESENCE. ALL ARE INTERESTED IN AGGRESSIVE THERAPY AT THIS TIME. I REVIEWED THE ROLE OF RADIATION THERAPY, PALLIATIVE XRT TO THE BRAIN OF 3000 cGy IN 10 FRACTIONS. I DISCUSSED THE SIDE EFFECTS AND RISKS AND WE WILL INITIATE THE TREATMENT TOMORROW. WE WILL ALSO

CONSIDER CONCURRENT CHEMOTHERAPY TO ADDRESS HIS SYSTEMIC DISEASE.

/s/ Thomas J. Pedrick
THOMAS J. PEDRICK, M.D.
RADIATION ONCOLOGIST

TJP/JEP

Reg. Dist. No. 25
Primary Reg. Dist. No. 7501
Registrar's No. 7233

DO NOT WRITE IN MARGIN RESERVED FOR OOH DATA CODING
a. _____
b. _____
c. _____
d. _____
e. _____

Ohio Department of Health
VITAL STATISTICS
CERTIFICATE OF DEATH State File No.
TYPE OR PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT'S NAME (First, Middle, LAST)						2. SEX	3. DATE OF DEATH (Month, Day, Year)
ISAAC JOHN ROBERSON JR.						MALE	OCTOBER 10, 1995
4. SOCIAL SECURITY NUMBER	5a. AGE – Last Birthday (Years)	5b. UNDER 1 YEAR Months	Days	5c. UNDER 1 DAY Hours	Minutes	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
[Omitted]	60					JULY 22, 1935	TRENTON, N.C.

8. WAS DECEDENT EVER IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one) HOSPITAL:	OTHER:
XX☐ Yes ☐ No	XX☐ Inpatient ☐ ER/Outpatient ☐ DOA	☐ Nursing Home ☐ Residence ☐ Other (Specify)

IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION →

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, VILLAGE, TWP., OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST ANNS HOSPITAL	COLUMBUS	FRANKLIN

10. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY
MARRIED	CATHERINE DUPREE	DRIVER	US POST OFFICE

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, TWP., OR LOCATION	13d. STREET AND NUMBER
OHIO	FRANKLIN	COLUMBUS	7612 WYNDOVER PLACE

13e. INSIDE CITY LIMITS? (Yes or No)	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes – If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify:	15. RACE – American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4,R St)
YES	43204	☒ No ☐ Yes	BLACK		3

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
ISAAC JOHN ROBERSON SR.	CONSTANCE UNK

INFORMANT

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CATHERINE ROBERSON	7612 WYNDOVER PLACE, COLUMBUS, OHIO 43204

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION – City or Town, State
☒ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)	ORNYTOWN VETERANS MEMORIAL	ORNYTOWN, NEW JERSEY

20d. DATE OF DISPOSITION	21a. NAME OF EMBALMER	21b. LICENSE NUMBER
OCTOBER 14, 1995	DAVID GARY	6787A

REGISTRAR

22a. SIGNATURE OF FUNERAL DIRECTOR OR OTHER PERSON	22b. LICENSE NUMBER (of Licensee)	23. NAME AND ADDRESS OF FACILITY
▶ /s/ David Gary	5949	GARY MEMORIAL CHAPEL 2154 E. MAIN ST. COLUMBUS, OHIO 43209

24. REGISTRAR'S SIGNATURE	25. DATE FILED (Month, Day, Year)
▶ /s/ Kimberly S. Mills	10-12-95

26a. SIGNATURE OF PERSON ISSUING PERMIT	26b. DIST. No.	27. DATE PERMIT ISSUED
▶	25	10-11-95

CERTIFIER

CAUSE OF DEATH

EE INSTRUCTIONS
N OTHER SIDE

28a. CERTIFIER *(Check only one)*

☒ CERTIFYING PHYSICIAN
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

28b. TIME OF DEATH	28c. DATE PRONOUNCED DEAD *(Month, Day, Year)*	28d. WAS CASE REFERRED TO CORONER?
10:30 P.M.	10/10/95	☐ Yes ☒ No

28e. SIGNATURE AND TITLE OF CERTIFIER	28f. LICENSE NUMBER	28g. DATE SIGNED *(Month, Day, Year)*
▶ /s/ D. Ranade M.D.	42815	10/12/95

29. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH *(Type/Print)*
DILIP K. RANADE, M.D./492 E. BROAD ST. STE. 1203 COLUMBUS, OHIO 43205

30. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. TYPE OR PRINT IN PERMANENT BLACK INK.

		Approximate Interval Onset and Death
IMMEDIATE CAUSE (Final disease or condition → resulting in death)	a. CARDIAC ARRHYTHMIA	Minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PNEUMONIA	DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. METASTATIC CANCER	MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. SIP CVA	MONTHS

PART II. *Other significant conditions* contributing to death but not resulting in the underlying cause given in Part I.

31a. WAS AN AUTOPSY PERFORMED?	31b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☐ Yes ☑ No	☐ Yes ☐ No

32. MANNER OF DEATH	33a. DATE OF INJURY *(Month, Day, Year)*	33b. TIME OF INJURY	33c. INJURY AT WORK?	33d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide		M	☐ Yes ☐ No	

33e. PLACE OF INJURY – At home, farm, street, factory, office building, etc. *(Specify)*

33f. LOCATION *(Street and Number or Rural Route Number, City or Town, State)*

5152.06 Rev. 3/81

INFORMATION CONCERNING THE BURIAL OF DECEASED MEMBERS AND FORMER MEMBERS OF THE ARMED FORCES OF THE UNITED STATES

FUNERAL DIRECTORS ARE REQUIRED BY LAW TO FURNISH THE FOLLOWING ADDITIONAL INFORMATION FOR DECEASED MEMBERS OR FORMER MEMBERS OF THE ARMED FORCES.

Name of deceased ISAAC JOHN ROBERSON JR.

Date of death 10-10-95

State of birth NORTH CAROLINA

Date of birth 7-22-35

Branch of service ARMY

Date of entry into service 2-26-56

Type of separation or discharge from service HONORABLE

Date 2-13-59

Name of cemetery ORNYTOWN VETERANS MEMORIAL

Date of burial 10-14-95

Location of cemetery

County MAMMOUTH City ORNYTOWN

Township – Village –

Name or number of section in cemetery 4A

Number of lot 1-1023 Number of grave 35

Information relative to a deceased veteran may be secured from the Veteran's Discharge Papers.

INSTRUCTIONS – CAUSE OF DEATH

The cause of death means the diseases, abnormality, injury, or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

In Part I, the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify.

In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

EXAMPLE No. 1

CAUSE OF DEATH

30. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition → resulting in death)	a. Rupture of myocardium	Mins.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute myocardial infarction	6 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic ischemic heart disease	5 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. *Other significant conditions* contributing to death but not resulting in the underlying cause given in Part I.	31a. WAS AN AUTOPSY PERFORMED?	31b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Diabetes, Chronic obstructive pulmonary disease, smoking	☒ Yes ☐ No	☒ Yes ☐ No

32. MANNER OF DEATH	33a. DATE OF INJURY (*Month, Day, Year*)	33b. TIME OF INJURY	33c. INJURY AT WORK?	33d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Could not be Determined ☐ Suicide ☐ Homicide		M	☐ Yes ☐ No	
	33e. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (*Specify*)			33f. LOCATION (*Street and Number or Rural Route Number, City or Town, State*)

EXAMPLE No. 1

CAUSE OF DEATH

30. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition → resulting in death) a. Cerebral laceration	10 mins
DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Open skull fracture	10 mins
DUE TO (OR AS A CONSEQUENCE OF):	
c. Automobile accident	10 mins
DUE TO (OR AS A CONSEQUENCE OF):	
d.	

PART II. *Other significant conditions* contributing to death but not resulting in the underlying cause given in Part I.

31a. WAS AN AUTOPSY PERFORMED?	31b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☐ Yes ☐ No	☐ Yes ☐ No

32. MANNER OF DEATH	33a. DATE OF INJURY (*Month, Day, Year*)	33b. TIME OF INJURY	33c. INJURY AT WORK?	33d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide	11/15/85	1 p. M	☐ Yes ☒ No	2-car collision-driver

33e. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (*Specify*)	33f. LOCATION (*Street and Number or Rural Route Number, City or Town, State*)
Street	Route 5, Raleigh, Ohio

MEDICAL RECORD PROGRESS NOTES

PHYSICAL MEDICINE
& REHAB SERVICE

DATE

F/U

1-12-95 Cancelled

1-26-95 D. CVA – Lt. hemiplegia

Disabilities =

1. Nonfunctional Lt. upper extremity with pain in Lt. shoulder.
2. spastic weakness of Lt. with lower with exb with HKAFD
3. Ambulatory with brace quad cane for very short distance.
4. Confined to semi-recline chart at home most of time
5. Partially independent in ADL

Rx. Resume PT & OT to improve the general strength & ADL.

RTC one month

[illegible]

AMPUTEE

1/6/95 He was seen at amputee clinic 12/7/94 for re-eval KAFO. Clinic team impression was that if anything an AFO might be helpful – but before trying a custom-made AFO it was decided to see if an AFO would be useful by modifying his *old* AFO with moveable Ankle.

Ankle was fixed at 90° to use floor reaction force when walk to ↑ knee stability. This attempt resulted in problems with toe clearance & AFO was modified *again* in some dorsiflexion → which caused ↑ knee *in* stability – patient fell x2 @ home per wife.

Imp patient is a poor orthotic candidate per team consensus. We would have to get an HKAFO long leg brace to improve stability – which would make walk even more [illegible] Disp – Attempted to explain to patient and his wife above thought process and why no solution possible.

Zulier

2/24/94 Client to O.T. for neuromuscular reeducation techniques to maximize ROM and inhibit tone. Client with notable ↑ in joint stiffness. Emphasized home follow thru refill [illegible]

2-24-95 PT eval see form. Will see pt for ex-and gait training. He will be at Chillicothe VA for respit care next week while his wife is out of town

Will call for further appointment Linda Wilson PT

VAMC CHILLICOTHE 04/28/95 17.34 Page: 1

PATIENT NAME	AGE	SEX	RACE	SSN	CLAIM
ROBERSON, ISAAC	59	M	BLAC	[Social Security Number Omitted]	NUMBER 239467598

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD
MAR 03, 1995	MAR 18, 1995	OPT-SC	15	0	NO 210CD

DICTATION DATE: APR 10, 1995

TRANSCRIPTION DATE: APR 28, 1995

TRANSCRIPTIONIST: HITCHENS, REBECCA

DIAGNOSIS:

X 1. Previous cerebrovascular accident with left hemiparesis.
2. Hypertension, benign, essential
3. Peripheral vascular disease.
4. Gout.
5. Arthritis.
6. Respite care.
7. Coryza with mild pharyngitis.

PERTINENT CLINICAL DIAGNOSIS NOTED BUT NOT TREATED:

OPERATIONS/PROCEDURES PERFORMED DURING THIS EPISODE OF CARE:

RMS for KT and OT 3/7/95.

SUMMARY: 5/15/95 Review-PTF Completed

PROVISIONAL DIAGNOSIS: Respite care, pharyngitis and old CVA.

SUBJECTIVE: This was the most recent VAMC Chillicothe admission for this 60 year old veteran who was admitted on 3/3/95 coming from his home in Columbus, Ohio, for a period of respite care. He is known to have a history of previous CVA and hypertension and has been hospitalized here in the past on the long-term care service. Other than pharyngitis and complaints of head cold, the patient had no other specific complaints.

OBJECTIVE: Physical examination at the time of admission revealed an alert, well-developed male in a wheel chair. He was in no acute distress. He was cooperative and oriented. HEENT The pharynx was somewhat injected. There was no exudate noted. Neck was supple, chest was clear, heart was normal sinus rhythm without murmurs or gallops. Abdomen was soft; bowel sounds were active. Extremities showed full passive range of motion of lower extremities. There was a left leg brace; left hemiparesis noted. He was alert, cooperative and oriented with relevant speech. No apparent problems with hearing or vision.

LABORATORY: Throat culture and sensitivity was negative. Urinalysis showed just a trace of bacteria. EKG initially showed a sinus bradycardia with nonspecific ST and T wave changes. Follow up showed a junctional rhythm. BUN, electrolytes and creatinine were normal. BUN was slightly elevated to 25 and

creatinine was 1.6. Liver function studies were normal. Cholesterol was 147, CBC was normal.

COURSE OF HOSPITAL: He was initially admitted to Acute Medical Service, Building 30CD. He was on Erythromycin 250mg/qid for 10 days, pureed low sodium diet, Persantine 50mg/tid, EC ASA grains 5/qd, Diltiazem 90mg/tid, Ramipril 2.5mg/qd, Baclofen 10mg/tid, Allopurinol 300mg/qd, Motrin 400mg/tid/pc, Atenolol 25mg/qd. By 3/6 the patient was transferred to Intermediate Medicine, building 26AB, on the same diet and medications. His OT and KT instructions were continued. An overhead trapeze was placed on his bed. He was given Chlor-Trimeton 4mg/q6h prn for five days for a head cold. During the course of his hospitalization on Intermediate Service, he had no exacerbations of his pre-existing condition. He remained ambulatory with a wheelchair. He was independent about the ward and basically did quite well during this stay.

DISCHARGE AND AFTERCARE PLAN: The patient was admitted for a two week respite care program 3/3 through 3/18. This was completed without incident. He was treated for a mild pharyngitis. Culture showed no specific bacteria or growth. He was discharged to his home at 7612 Windover Place, Black Lick, Ohio 43004. At the time of discharge he was considered to be competent for VA purposes, and he was 10% service connected. His discharge medications included:

Atenolol 25mg/qd
Motrin 400mg/tid
Allopurinol 300mg/qd
Persantine 50 mg/tid
EC ASA grains 5/qd
Diltiazem 90mg/tid
Ramipril 2.5mg/qd
Baclofen 10mg/tid
MOM and Tylenol on prn basis.

He was advised to maintain a regular, no added salt diet.

PATIENT EDUCATION: During his stay on Intermediate Service the patient was educated regarding his diagnosis, medications, diet, activity limitations. He is well versed in his medical needs and need for follow up and will comply through the outpatient clinic in Columbus, Ohio. He was advised to contact the local emergency room should any emergency arise. Otherwise, any questions could be directed toward this medical center or the outpatient clinic.

DICTATED BY: SIGNATURE APPROVING PHYSICIAN/DENTIST

/s/ Q

GARY SALLADE MARY G. QUE, M.D.

PATIENT: ROBERSON, ISAAC
[Social Security Number Omitted]

VA FORM 10-1000 CHART COPY
DISCHARGE SUMMARY

MEDICAL RECORD PROGRESS NOTES

PHYSICAL MEDICINE
& REHAB SERVICE

DATE

4-13-95 DX CVA old.

Disability – Lt. hemiparesis
Lt.neglect

Appliances & AID. w/c. quad cane, hospital bed, shower chairs, grab bar, toilet seat, lift chair.

Home health care 3 times /w.

Live with wife, : 5 lunches /w provided by meals on wheels services.

He is partially able to walk with supervision

He is partially independent in ADL.

TX PT & OT Heading pad.

RTC one month.

[illegible]

4/14/95 Medicine

95 P 56 R 16 B/P 142/90 RAS

Ag 59 Wt n/c Ht 5'10"
Smoker

Joyce Brown LPN

problems : as previous

4/26/95 PM RS DT

4/26/95 Vet to O.T. Supine on mat completed VE PROM in all ranges throughout. Reviewed HEP with SROM from supine with emphasis on *slow* stretches at sh., elbow ext. Encourage regular follow through, as pt. admits he has not been completing any ex's @ home.

M Strall COTA/L
[illegible]

4-26-95 P.T. standing balance in all directions. gait training with quad cane. He can position cane correctly with V.A. He needs to ↑ pressure on cane to ↓ cut on LLE. He states he has pain in his knee & a brace has been ordered (per pt. statement.) He is going to check with prosthetics about it. L. Wilson PT

4/28/95 Vet to O.T. Continued mat ax's; completed L VE PROM in all ranges throughout. Noted ↓ stiffness L VE Pt. has begun to follow through on SROM ax's as instructed. Using hemi dressing techniques to doff/don jacket, shirt I to continue.

M Strall COTA/L
[illegible]

5/3/95 Vet to O.T. Treatment as above. Pt. reports ↓ follow through He d/t illness." W/C brakes tightened as they were not locking & unsafe. Continue to review hemi dressing techniques. To continue.

M. Strall COTA/L
[illegible]

5/11/95 PM & RS Flu

CVA – Lt hemiparesis

Mild spacial perception prescription problems.

No evidence of Lt. hemianopia

No function of Lt. upper extremity.

Sporatic paralysis of Lt. lower extremity

Ambulation & AFO (short leg brace) and quad cane for a short distance.

Independence of ADL with assistance at home.

Rx Continue PT & OT to increase general strength and skills of ADL.

RTC 2 months [illegible]

6-7-95 Medical – pt. wife here with d/c meds – pt in unscheduled seen for Dr. Lim. Cancelled RMC R/O STROKE had TIA new med – [illegible] BID, [illegible] XL 60 qd HTL 25 qd Atenolol 2.5 mg qd Found to be hyper[illegible] CT no [illegible]

Register No. Ward No.

NAME	AGE	SEX	ATTENDING PHYSICIAN
Isaac Roberson	59	M	Delphia

CHIEF COMPLIANT

Slurred speech

HISTORY OF PRESENT ILLNESS

Pt is a 59 yo BM with remote MI, S/p CVA x2 ('88, '90), HTN. Pt presents to ER with wife with chief complaint of progressively ↑s slurred speech over the past week. Pt denies "ha", has [Illegible] baseline Head Pressure, No visual os – Blurred with black spots (has had previously – before os), no nausea/vomiting, no [illegible] parathesias or ↑ weakness. Pt fell yesterday because "leg just gave out" on him, trauma to neck.

PAST HISTORY (INCLUDE MEDICATIONS, ALLERGIES, PREVIOUS SURGERY)

All's – 0
Surg's –
Appy
Rotator Cuff

Ill's – MF – '74
CVA x2 – '90-
HTN
GDM, CEA Cancer

Meds-DOSES???
Coumadin
Procarda
Zotrin
Hydrochlorthiazid
Baclofen 10mg-tid
Atenolol
ASA
Allopurinol
Persantine
Lisinopril
See nurse's H/P

FAMILY HISTORY

Dad CVA, mom cerebral clot; HTN

SOCIAL HISTORY

59 yo BM; liver [Illegible], 10 cigs x 40 yrs. and use now no ETOH
Coffee-3 cups/wk

REVIEW OF SYSTEMS

– Fev/chills
– cough, SOB, LP
– [Illegible]

– parasthesia, weakness spasm)
– melana, BRBPR

COMPLETED BY DATE TIME

PHYSICIAN SIGNATURE

/s/ [Illegible] 6/5/95 [Illegible]

[LOGO] **PERSONAL HISTORY**

ROBERSON, ISAAC JR
C07/22/35 M 59
DELPHIA, MICHAEL J., M.D.
CC5751 5053

ENTATIVE DIAGNOSIS		BP	P	R
R/O CVA /TIA	T 97.2	122/74	80	16

GENERAL
Fidgety

SKIN
Wtd 0 legion

HEAD/NECK
NCAT x ® carotis Endaitia scar-bruts App. rec'd [illegible]

ENT
Unable to visualize fundi Pupils reactive, rivals fields intact by approx, poor dentition
Tongue deviates Rt to Lt

BREAST

HEART
[Illegible] heart [Illegible] Reg, Brag, No Ect [Illegible]

LUNGS

ABDOMEN
[Illegible], soft NT diffusely

6/5/95

REPRODUCTIVE
Defernes

RECTAL

EXTREMITIES
MO ex4, UT, LUP

NEUROLOGIC
Strength 3/5: 315 LUE, LLE, 5/5 RUE, RLE
Intact [Illegible] sensory definition

OTHER FINDINGS

143	111	31 <98	VI Aod 3.8	6.9	14.4	196
4.8	27	1.8	Chem 12	43.5		
			wn1	MIV 107		
			[illegible]	MIH 35.21		
				Macro		

EKG:
sinus brady
> 40 bpm
No Acute
[Illegible]
CXR:
HEAD CT
old® infarct
[illegible]

IMPRESSION/DIAGNOSIS

· 59 yo BM past CVAs 1 wk lt slurred speech & fall yesterday otherwise stable - not Crescendo St's RCO CVA, TIA → Head CT neg after 1 wk of symptoms

PLANNED TREATMENT
Plan – [Illegible]
✓ Dopplers (Carotid), Echos
Will not coumedin [illegible] ↑ symptoms & falling history
2 BP control – Hold BP meds d/t need for
↑ perfusion pressure
Pin Proc SBP >180 DBP >100

Bragcardia – Tele –
Rev EKG Am
Hold meds d/t
2° rate ↓
CB [illegible]

MEDICAL RECORD PROGRESS NOTES

PHYSICAL MEDICINE
& REHAB SERVICE

DATE

5-30-95 Worked on sitting balance > standing.

Pt. [Illegible] LBP initially so-what better p exercise gait with quad cane 10' varies with shuffle steps with no weight into cane. Suggested practice upright sitting posture at home

Donna Lindsey

5-31-95 J: Pt. indicates he still doesn't follow through with exercise. He seems interested in day ty program.

a: Worked on standing balance and wt. shift. Unable to tolerate strong challenges to wt shift.

A: Feel pt. may benefit from day ty, but has reached his potential with PT.

P: Will D/C PT next Ty. pt. will not benefit from further physical therapy.

[illegible] Thomas, PT. #3956

[LOGO] Department of Veterans Affairs	MEDICAL RECORD	OVERALL TREATMENT PLAN

IMPORTANT: CHECK APPROPRIATE BOX:
☐ INITIAL ☐ CHANGE TO TREATMENT PLAN
☐ DISCHARGE PLANNING

INSTRUCTIONS: *Following an assessment of the patient's problems, the initial treatment plan will be documented on this form. This plan will specify the overall diagnostic and therapeutic activities that will be undertaken in regard to each of the patient's problems and the specific staff members responsible for carrying out these activities. Specific mention will be made of plans for specialized rehabilitation services, patient education, discharge, and followup. Revisions of the treatment plan will be made on this form, if appropriate, or in additional copies of this form. (VAF 1 O-0043a will be used. Service Treatment Plan, if needed.)*

Date: 6-22-95

Chief Complaint:

[Referred to [illegible] Sharon P.D for socialization + mild Phys. activities.]

Psychological Assessment:

[Adjustment reaction to CVA, at time gets agitated, anxious, frustrated, re inability to do things or make self understood at times S/H,]

Physical Assessment:

[Previous CVA in L hemiparesis
HIN, Arthritis]

Socio-Cultural Assessment:

[59 yo married, 10% ?SC-Arthritis, disabled/
unemployed]

Initial Treatment Plan:

____ 1. Refer to psychologist.
____ 2. Refer to physician.
____ 3. Refer to social worker
____ 4. Make arrangements to see family or reliable person.
____ 5. Return to clinic on _____
✓ 6. Refer to Day Treatment Center

Tentative Impression (Diagnosis):
309 Adjustment DISORDER

(Patient's Signature) (Telephone number)

(Relative) (Relative's number)

(Address) (Primary Therapist)

SIGNATURE/TITLE-PRACTITIONER	SIGNATURE/ INITIAL OF APPROV-ING PHYSICIAN	DATE
/s/ [Illegible] MSW		6-22-95

Enter in space below – PATIENT IDENTIFICATION – Treating Facility – Ward No. Date *U.S. GPO:1993-343-134/74312	**MEDICAL RECORD OVERALL TREATMENT PLAN**
/s/ Roberson, [Illegible] 7598	VA FORM **10-0043** SEPT 1989

PATHOLOGY DEPARTMENT
Riverside Methodist Hospitals
Columbus, Ohio 43214
(614) 566-5526
CYTOPATHOLOGY

SUSAN A. FUHMAN, M.D. JANET C. PERRY, M.D.
PETER A. ACCETTA, M.D. MARTIN L. KELSTON, M.D.
M.S.N. MURPHY M.D. CHARLES J. NICELY, M.D.
MELANIE C. DOLOR M.D. RONALD E. FYEA, M.D.
AUGUSTO AGUIRRE M.D. MICHAEL P. SAUNA, M.D.
MARK D. BROWNELL M.D. KEVIN F. FORSTHOEFEL, M.D.

Billing #: 1001832789
Name: ROBERSON, ISAAC JR
DOB: 07/22/35
Age: 60Y Sex: M
M.R. #: 505302
Location: 412201
Attending: MEAGHER, MICHAEL, M.D.

Date of Collection: 08/21/95
Aspirating Physician: DICKSON, STEPHEN
MAILBOX ROW 21

Cytopathology Spec. #: C95-16174
Date Received: 08/21/95
Date Reported: 08/22/95
cc: >

Site Aspirated: Right supraclavicular neck node

Clinical Diagnosis: >

Clinical History: Rule out metastatic prostatic carcinoma. Patient had two CVA's in 1990. Now has multiple subcutaneous masses and a large cerebellar mass and metastasis to the liver. Cervical mass is 5 cm in diameter

FINE NEEDLE BIOPSY CONSULTATION

Preparations Examined: SMEAR(S) 04

MICROSCOPIC DIAGNOSIS:

LYMPH NODE, RIGHT SUPRACLAVICULAR:

METASTATIC UNDIFFERENTIATED SMALL CELL CARCINOMA. *#

COMMENT: The smears contain fragments of neoplasm which are characterized by small cells which are larger than lymphocytes with hyperchromatic nuclei and with nuclear molding. The cytologic pattern is suggestive of a primary from lung. Clinical correlation is advised.

MCD/jym

/s/ Melinda C. Dolor, M.D.
MELINDA C. DOLOR, M.D.

[LOGO]

COLUMBUS
ONCOLOGY
ASSOCIATES,
INC.

Scott C. Blair, M.D.
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Mellar P. Davis, M.D.
Medical Oncology & Hematology

Christopher S. George, M.D.
Medical Oncology & Hematology

J. Philip Kuebler M.D., PhD.
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St. Anne's Medical Building
495 Cooper Road
Suite 414
Westerville, Ohio 43081-8998
614/898-5514

January 29, 1998

Mrs. Catherine Roberson
7612 Wyndover Place
Blacklick, Ohio 43004

RE: Isaac Roberson, Jr.
SSN: [Social Security Number Omitted]

Dear Mrs. Roberson:

As you requested, I am sending a copy of the initial consultation report which I made on August 22, 1995. This is the only information which I have in his chart here, and perhaps additional information would be available either through the Cigna or the Riverside Hospital records.

At the time of the original presentation in August 1995, it was apparent the he already had brain involvement from his tumor, and in addition, the CAT scan showed extensive involvement in the liver, lymph nodes, and lung. Therefore, his disease was advanced at the time of diagnosis.

Since small-cell carcinomas of the lung are one of the more rapidly growing tumors, it is likely that this advanced very quickly and had not been present for a long period of time. It is unclear as to how long it could have been detected, but an onset perhaps four to eight months prior to his diagnosis in August would be reasonable.

If additional information is needed, please let me know.

Sincerely,

/s/ James Pritchard
James D. Pritchard, M.D.

JDP/ptcl
Enclosure

[SEAL]

Department of Veteran Affairs **Memorandum**

Date: July 14, 2003

From: Bronx VA Medical Center

Subj: Isaac Robertson
[Social Security Number Omitted]

To: Board of Veterans Appeals

Thru:

The claims folder on Mr. Robertson was reviewed in its entirety. The following medical summary has been prepared using the many medical records contained in the c-file.

The C&P Exam Inquiry specifically asked the following questions:

a. All clinical records should be reviewed by an appropriate specialist in the treatment of cancer.

b. What disorder caused the veteran's death?

c. What is the likely range of time of the onset of the disorder which ultimately led to the veteran's death?

d. When is it likely that this disorder was first manifested or diagnosable?

e. Did VA fail, during a period of VA treatment, to diagnose the disorder which caused the veteran's death, when a physician exercising the degree of skill and care ordinarily required of the medical profession

reasonably should have diagnosed the condition and rendered treatment?

f. If so, did the veteran suffer disability or death which probably would have been avoided if proper diagnosis and treatment had been rendered?

1. Mr. Robertson (date of birth 7/22/35) was treated by several medical providers in the five (5) years prior to his death in October, 1995. Records from each of these providers were reviewed. He was known to have multiple CVA's, a right carotid endarterectomy and a TURP in the early 1980's. There is no documentation that the prostate was cancerous. The following episodes of care are relevant to his terminal condition:

a. May-June 1988 – Passaic Hospital. The veteran suffered a right frontotemporal infarct and cerebrovascular accident. He was noted to be a 2 pack per day smoker. He had complete occlusion of the right carotid artery on both sonography and angiography.

b. Feb. 2, 1992 – Riverside Methodist Hospital. A chest x-ray showed sclerotic bones that were suspected of being artifact.

c. April, 1993 – VA Chillocothe. Upon examination the patient states that he is well. A CT scan of the head performed 5/7/93 showed a right temporoparietal infarct.

d. July 22, 1993 – VA hospital. Respite admission. The patient had no complaints requiring medical investigation.

e. March 21, 1994 – VA hospital. CT of the head showed a right temperofrontal infarct.

f. Feb. 3, 1995 – VA hospital. Physical examination of the neck and lungs was unremarkable (normal).

g. March 13-18, 1995 – VA hospital respite admission. Patient complained of pharyngitis and a head cold. No other specific complaints were elicited from the patient.

h. June 5, 1995 – Riverside Methodist hospital. Patient complained of having a fall and hitting the back of his head. Denies headache, but states he has baseline head pressure. There were no visual changes, nausea, vomiting or increased weakness. CT of the head performed showed old frontal temporal infarct on the right, no acute changes.

i. June 29, 1995 – VA hospital day treatment Center. The patient attended a picnic and fishing field trip (no apparent ill health).

j. July 25-Aug 1, 1995 – Riverside Methodist hospital. Admitted for increasing difficulty with speech, walking and self-care. The discharge summary does not indicate that any medical issues were present. The discharge diagnoses were CVA and hypertension.

k. Aug 14, 1995 – Riverside Methodist hospital. CT scan of the head showed a 5 cm right cerebellar mass with secondary hydrocephalus. Chest xray showed bony skeleton was diffusely sclerotic. Lungs were reported as clear.

l. Aug. 15, 1995 – Riverside Methodist hospital. A right supraclavicular mass was felt and a right lower abdominal mass was noted.

m. Aug 16, 1995 – Riverside Methodist hospital. CT of the brain without contrast. The radiology report specifically states that comparison was made to the previous examinations of 6/5/95 and 8/14/95. "The patient has very dilated ventricles. This was not present on 6/5 and it is about the same as seen on 8/14. There is a large area of infarction seen in the right frontal lobe. Some high attenuation is seen adjacent to this which was not apparent on 6/5 even though the infarct was apparent on 6/5 and it is a bit more obvious today than when seen on 8/14. Conclusions – development in two months of an apparent mass in the cerebellum."

n. Aug. 18, 1995 – Riverside Methodist hospital. MRI of the head showed a 5 cm mass and a 2.2 cm right frontal mass. Chest xray was normal, with increased bone density. CT of the chest and abdomen showed multiple subcutaneous masses, large liver and nodal metastases, no definite lung primary lesion was found.

o. Aug. 21, 1995 – Riverside Methodist hospital. Fine needle biopsy of the right supraclavicular node

read as metastatic undifferentiated small cell carcinoma. (Fragments of neoplasm which are characterized by small cells which are larger than lymphocytes with hyperchromatic nuclei and with nuclear molding. The cytologic pattern is suggestive of a primary from lung.)

p. There is a note of 8/30/95 that states that the patient previously had a head CT scan that showed old infarct, but no evidence of malignancy.

q. Oct 4-10, 1995 – Final admission to Riverside Methodist hospital. Patient was admitted for acute respiratory distress. At the time of admission he was receiving TPN therapy via a CVP line in the chest, he had a Greenfield filter placed for management of deep venous thrombosis, he had an indwelling Foley catheter, he had a ventriculostomy shunt which was placed for management of hydrocephalus and he was noted to have sacral and spine decubiti. His CXR on admission showed probable right lower lung mass with bilateral basilar infiltrates. His PSA was 3.4. On Oct. 4, he was noted to have axillary adenopathy on exam. On Oct 5 two sets of blood cultures grew Serratia Marcescens. Sputum culture of 10/9 showed Pseudomonas, Proteus, Klebsiella and S. Aureus. Although the death certificate states that death was due to cardiac arrhythmia due to pneumonia, due to metastatic lung cancer, there is NO evidence in the record to prove that the small cell cancer from which he suffered originated in the lung. The nature of the pneumonia (bilateral basilar infiltrates) is consistent with aspiration pneumonia, not the post-obstructive

pneumonia generally seen in the presence of a lung cancer.

2. Specific questions as posed by Board of Veterans Appeal

a. The medical records have been reviewed in their entirety and are summarized above.

b. What disorder caused the veterans death?

The veteran's death was caused by Serratia Marcescens septicemia and aspiration pneumonia. These disorders were likely a complication of the metastatic cancer of UNDETERMINED PRIMARY. The pathology report states that small cell cancer was LIKELY of pulmonary origin, but this theory is not supported with radiology or pathology findings. Other possible primary sites for this cancer include head and neck tumors, prostate and bowel.

c. What is the likely range of time of the onset of the disorder which ultimately led to the veterans' death?

The likely range of time of the onset of the septicemia and aspiration pneumonia was no more than 10 days prior to death. The likely range of time of onset for the metastatic cancer is probably 4-6 months. Neither of the brain metastases was detectable on CT scan of the head June, 1995, four months prior to death. The second of the two brain metastases was undetectable on CT scan of the head on 8/14/95, two days before it was discovered on 8/16/95. A similar rate of growth can be projected for the neck mass which was

discovered 8/15/95, the biopsy of which yielded the diagnosis of small cell carcinoma of undetermined primary source and for the axillary nodes which were discovered on Oct. 1995.

d. When is it likely that this disorder was first manifested or diagnosable?

The multiple scans and xrays that were performed in 1995 prove that the disorder was first manifested in August, 1995. It was not present on testing prior to July, 1995. The patient was not seen at the VA for medical treatment after March 18, 1995. In March, 1995, there was no evidence to suggest that cancer was present.

e. Did VA fail, during a period of VA treatment, to diagnose the disorder which caused the veteran's death?

NO. There are no symptoms recorded during the episodes of VA treatment suggestive of a medical condition that warranted further investigation. In the absence of a history to suggest a disorder other than the multiple strokes, and in the absence of a change in physical findings to suggest a new or worsening process, further investigative studies were not clinically indicated.

f. Did the veteran suffer disability or death which probably would have been avoided if proper diagnosis and treatment had been rendered?

It is impossible to say whether he could have been cured if the disease had been detected earlier. Death

from extensive small cell carcinoma with brain involvement usually, but not always, results in death within 10 months. Any individual patient, however, may not follow this statistic. Small cell carcinomas have a median survival with treatment of 10 months.

/s/ Herbert Edlis MD
Herbert Edlis, M.D.
Oncology

/s/ Carol Allen
Carol Allen, M.D.
Director, Administrative Medicine

COMPENSATION AND PENSION EXAM INQUIRY

Name: ROBERSON, ISAAC
SSN: [Omitted]
C-Number: [Omitted]
DOB: JUL 22, 1935
Address: 11 STONEWALL RD
APT 143
City, State, Zip+4: WASHINGTONVILLE,
NEW YORK 10992
Res Phone: Unknown
Bus Phone: Unknown
Entered active service: FEB 27, 1956
Released active service: FEB 13, 1959

==========

>>> Future C&P Appointments <<<

No future C & P appointments found.

Requested exams currently on file:
BRAIN AND SPINAL CORD
Requested on DEC 9, 2002@11:36:34 by BVA/VBA SUPPORT OFFICE – Open

---

This request was initiated on DEC 9, 2002 at 11:36:34
Requester: CLAYTON, JAMES R
Requesting Regional Office:
BVA/VBA SUPPORT OFFICE

Exams on this request:
BRAIN/SPINAL CORD

** Status of request:
New

No rated disabilities on file
Other Disabilities:

General Remarks:
CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER.

POA-Private attorney

NO EXAMINATION IS NECESSARY AT THIS TIME. A REVIEW OF THE CLAIMS FOLDER WITH VA MEDICAL OPINION IS REQUESTED.

After all additional evidence obtained during the above-requested development has been associated with the claims files, the claims files and all clinical records, including VA inpatient and outpatient treatment records, private inpatient and outpatient treatment records, and medical statements and opinions of record, should be reviewed by an appropriate specialist in the treatment of cancer, such as an oncologist. The reviewer(s) should be provided with the following summary of the evidence of record, with the addition of any other providers identified by the appellant during development requested above:

The veteran had active service from February 1956 to February 1959. His service medical records are not relevant to the claim that VA failed to timely diagnose the caner which caused his death. Clinical records reflect that the veteran suffered a myocardial infarction in 1974, a cerebrovascular accident (CVA) in 1988, and a second CVA in 1990.

Between January 1992 and the veteran's death in October 1995, he received medical or other health care from the following providers:

Mt. Carmel Hospital, January 1992, admitted for complaints of headache and muscle spasms

Riverside Methodist Hospitals, Columbus, Ohio, January 1992. Evaluation included CT examination of the head; chest x-ray disclosed mild prominence of the radiopaque nature of the bones, suggesting possible sclerosis, renal disease, or metastasis.

* VA outpatient care, Columbus and Chillicothe, numerous treatment visits for a variety of complaints between January 1992 to June 1995

* VA inpatient care, Chillicothe VAMC, February 1992 to March 1992; April 1993 to June 1993, July 1993 to August 1993; March 1995; examinations included CT of head in May 1993 and March 1994

* Principal Health Care of Ohio, from November 1991 to April 1993, outpatient care for a variety of complaints

* Mt. Carmel Hospital, February 1993, admitted following a fall at home

* Home Health services from the Columbus, Ohio, Health Department

* Riverside Methodist Hospitals, Columbus, Ohio, outpatient treatment or inpatient admissions including in June 1995, July 25, 1995 to August 8, 1995,

August 14, 1995 to September 14, 1995 (treatment of cancer including chemotherapy)

* Northland Terrace Nursing Home, August 1995 and September 1995 to October 1995

* St. Ann's Hospital, October 1995 – discharge summary of the veteran's terminal hospitalization reflects that he had pneumonia, and had metastatic undifferentiated small cell carcinoma, with metastases to the brain, liver and lymph system.

Other evidence of record includes a January 1998 private medical opinion that the veteran's small cell carcinoma has its onset four to eight months prior to diagnosis in August 1995.

The examiner should be asked to respond to the following:

– What disorder caused the veteran's death?

– What is the likely range of time of the onset of the disorder which ultimately led to the veteran's death?

– When is it likely that this disorder was first manifested or diagnosable?

– Did VA fail, during a period of VA treatment, to diagnose the disorder which caused the veteran's death, when a physician exercising the degree of skill and care ordinarily required of the medical profession reasonably should have diagnosed the condition and rendered treatment?

– If so, did the veteran suffer disability or death which probably would have been avoided if proper diagnosis and treatment had been rendered?

The examiner must state in the report that the claims folder has been reviewed. If the veteran does not report for the exam, please provide verification that the veteran did not report and a copy of the notification to the veteran of the examination.

Please return the claims folder and exam report to:

Board of Veterans Appeals
Case Development Unit (014DEV205)
810 Vermont Avenue, NW
Washington, DC 20420

If there are any questions regarding this action, please call Jim Clayton at (202) 565-5755.